



National Breast and Cervical Cancer Early Detection Program

PROGRAM MANUAL

**DP17-1701 Cancer Prevention and Control Programs
for State, Territorial, and Tribal Organizations**

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Division of Cancer Prevention and Control
Program Services Branch

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Overview



OVERVIEW

Background and History of the NBCCEDP

Breast cancer is the most commonly diagnosed cancer and the second leading cause of cancer death among women in the United States. The early detection and treatment of breast and cervical cancer through screening reduces mortality rates and greatly improves cancer patients' survival. However, there is a disproportionately low rate of screening among women of racial and ethnic minorities and among under- or uninsured women, which creates a wide gap in health outcomes between these women and other women in the United States. To address this health disparity, Congress authorized the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) through the Breast and Cervical Cancer Mortality Prevention Act of 1990, directing the Centers for Disease Control and Prevention (CDC) to implement a national strategic effort for increasing access to breast and cervical cancer screening and diagnostic services for women in need (See [Appendix A](#)). The goal of the NBCCEDP is to decrease cancer incidence, morbidity, and mortality by focusing on underserved populations, who have increased cancer risk due to health disparities. CDC is pleased to offer this NBCCEDP Program Manual to grantees to provide an understanding of the NBCCEDP. The content is based on both current literature and the experience of those currently working in this program. This manual is intended to assist programs in meeting the requirements of the NBCCEDP as set forth in both the federal law and CDC guidance (including the Funding Opportunity Announcement DP17-1702). This will be a living document that will be updated as required during the 5-year funding period and available on nbccedp.org web site.

The NBCCEDP is administered by CDC's Division of Cancer Prevention and Control (DCPC) through cooperative agreements. Since 1991, the program has grown to include all 50 U.S. states, the District of Columbia, 6 U.S. territories, and 13 tribes or tribal organizations. Women diagnosed with cancer through the program are eligible for treatment through Medicaid coverage as authorized by the Breast and Cervical Cancer Treatment and Prevention Act passed by Congress in 2000.

As of June 2016, the NBCCEDP has served more than 5.3 million women, provided more than 12.7 million breast and cervical cancer screening examinations, and diagnosed more than



63,293 invasive breast cancers, 20,349 premalignant breast lesions, 4,360 invasive cervical cancers, and 199,599 premalignant cervical lesions, of which 39% were high-grade.

Target Populations

The NBCCEDP target population is uninsured or underinsured women who are at or below 250% of the federal poverty level, aged 40 to 64 years for breast cancer services, and aged 21-64 years for cervical cancer services. Grantees are required to describe their priority population based on available data such as race, ethnicity, gender, geography, socioeconomic status, health literacy, screening rates, and cancer incidence and mortality. Grantees are responsible for educating and motivating these women to seek screening; ensuring that services are convenient, accessible, and provided in a respectful, culturally competent manner; effectively communicating results; and recalling and assisting women who need additional services.

An estimated 9-11% of U.S. women of screening age are uninsured and eligible for NBCCEDP services. Priority is given to never screened women for cervical cancer services and women aged 50 to 64 years for breast cancer services. For 2010-2012 (the most recent year for which complete data are available), approximately 10.6% of NBCCEDP-eligible women aged 40–64 years were screened for breast cancer and 6.5% of eligible women aged 21–64 years were screened for cervical cancer through the program.

Underinsured women have large out-of-pocket cost sharing required by their health insurance plans that they cannot afford. This is often a barrier that prohibits a woman from getting appropriate testing needed. These women may be eligible to receive support from NBCCEDP to cover their out-of-pocket expense. However, CDC funds may not be used to pay for any portion of a test or procedure that would be paid for by another source (e.g., Medicaid or private insurance) under any circumstance and the total reimbursement must be limited to the Medicare rate. Grantees have the flexibility to determine whether to serve the underinsured within their program population and to define their program eligibility requirements.

While all segments of society are affected by cancer, there are certain populations that are disproportionately burdened by the increased risk of cancer or by the lack of adequate healthcare options for prevention and/or treatment. Grantees should seek to achieve health equity by targeting efforts to populations disproportionately affected by cancer. Relevant data should be utilized to identify these populations and to select culturally appropriate and evidence-based interventions for implementation.



Disproportionately burdened populations may be defined by sex, race, ethnicity, disability, sexual orientation, gender identity, geographic location, or socioeconomic status. Among the populations that will benefit from this funding are those living in rural and frontier geographic areas; culturally isolated women; incarcerated or institutionalized women; medically underserved women; women from minorities defined by race, religion, ethnicity, or culture, including African Americans, Alaska Natives, American Indians, Asian Americans, Pacific Islanders and Hispanics; lesbian, gay, bisexual, or transgender individuals; and women with low literacy, non-English speaking language barriers, and disabilities.

Healthy People 2020 Objectives

In accordance with the Healthy People 2020 objectives for the nation, this FOA focuses on addressing the national cancer burden. Measurable outcomes for awardees will be in alignment with the following performance objectives:

- Reduce the female breast cancer death rate (Healthy People C-3)
- Reduce the death rate from cancer of the uterine cervix (Healthy People C-4)
- Reduce invasive uterine cervical cancer (Healthy People C-10)
- Reduce late-stage female breast cancer (Healthy People C-11)
- Increase age-appropriate screening prevalence for cervical and breast cancer (Healthy People C-15 and C-17)
- Increase the proportion of women who were counseled by their providers about mammograms and Pap tests (Healthy People C-18.1 and C-18.2)

More information is available here: <https://www.healthypeople.gov/2020/topics-objectives/topic/cancer/objectives>.

NBCCEDP Focus

The main focus of the NBCCEDP is to provide direct screening and diagnostic services for breast and cervical cancer to eligible women. The eligible population for breast and cervical cancer screening in the NBCCEDP includes low-income (<250% FPL), uninsured, and underinsured women (i.e., whose health insurance does not fully cover screening and diagnostic services) meeting appropriate age requirements. Once a woman is enrolled in the NBCCEDP, the grantee is responsible for the provision of rescreening mammograms and Pap tests at appropriate, recommended screening intervals.

DP17-1701 NBCCEDP expands its activities to increase cancer screening and diagnostic services through population-based approaches focusing on health systems interventions, community



approaches that link women to clinical services, and environmental approaches that increase access to screening, especially at worksites. This requires more defined work within health systems and communities. Furthermore, the use of a more aggressive outreach approach, versus passive in-reach, is emphasized. Ultimately, a comprehensive public health approach is needed to increase access to high quality breast and cervical cancer screening and follow-up. This expanded focus will help to reduce disparities among vulnerable populations and missed screening opportunities for women who have health encounters. This approach is grounded in the National Center for Chronic Disease Prevention and Health Promotion's four Domains.

Domain 1: Epidemiology and Surveillance

Domain 2: Environmental Approaches

Domain 3: Health Care System Interventions

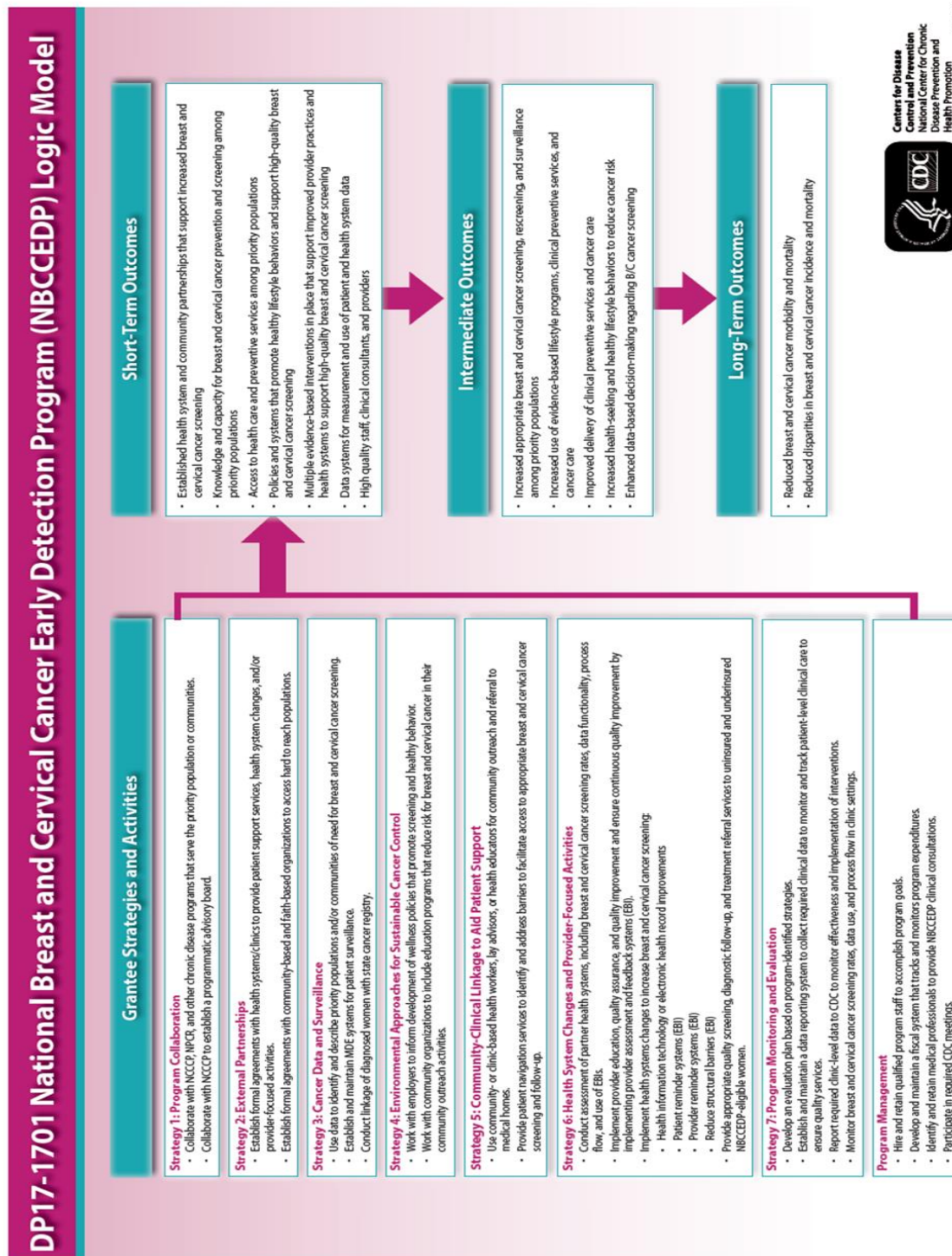
Domain 4: Community Programs Linked to Clinical Services

For NBCCEDP, this added emphasis is divided into 3 primary strategies (Health Systems Changes and Provider Focused Activities, Community-Clinical Linkages to Aid Patient Support, and Environmental Approaches for Sustainable Cancer Control) and 4 cross-cutting strategies (Program Collaboration, External Partnerships, Cancer Data and Surveillance, and Program Monitoring and Evaluation), along with Program Management. Expected activities for each strategy are described in more detail in this manual. **Grantees are required to implement all strategies to achieve program success (See [Appendix B](#)).**



Logic Model

The DP17-1701 NBCCEDP Logic Model depicts the work of the strategies in achieving intended outcomes.





Strategies



STRATEGIES

Health Systems Interventions and Provider Focused Activities

Definition

Under health systems change, grantees are expected to work at both the individual level and the population level by **1) providing direct clinical services and patient navigation support to eligible women** and **2) working with clinics within healthcare systems to enhance clinical service delivery among their appropriate patient population through implementation of evidence-based interventions.**

Health systems are important partners for NBCCEDP grantees. A health system is any “system for delivering healthcare that may include, for example, hospitals, clinics, health maintenance organizations (HMOs), and community health centers.” By working with a single health system to improve its breast and cervical cancer screening process, a grantee can reach many people who need to be screened for breast and cervical cancer.

Required Activities

Direct Clinical Services

Grantees should provide timely and appropriate breast and cervical cancer screening and diagnostic services to uninsured and underinsured women who meet NBCCEDP eligibility criteria of at or below 250% FPL, age 40-64 years for breast cancer services, and age 21-64 years for cervical cancer services. Grantees should also provide timely referral to treatment services for women diagnosed with breast or cervical cancer or pre-cancers.

See [Clinical Services](#) section for details on screening and diagnostic services.



Patient Navigation

For purposes of the NBCCEDP, patient navigation is defined as individualized assistance provided to women to help overcome barriers and facilitate timely access to quality screening and diagnostic services, as well as initiation of timely treatment for those diagnosed with cancer. Women often face significant barriers to accessing and completing cancer screening and diagnostic services. NBCCEDP grantees are required to provide patient navigation as a strategy aimed to reduce disparities by helping women overcome those barriers.

Grantees are required to:

- Provide patient navigation services to assist women receiving NBCCEDP-paid clinical services in overcoming barriers to complete screening, diagnostic services, and initiation of cancer treatment. All women with abnormal screening results **must** be assessed for their need of patient navigation services and provided with such services accordingly.

Grantees have the option to:

- Provide patient navigation services to assist low-income women from grantees' priority populations who have other payment sources (e.g., state funds, Medicaid) for screening and/or diagnostic services. CDC refers to this service as "navigation-only". Women receiving navigation-only services will be included in CDC's reporting of women served through the NBCCEDP beginning in January 2019.

Priority Populations for Navigation-Only Services

The target population for navigation-only services should be predominantly low-income women ($\leq 250\%$ FPL) and be of appropriate age per USPSTF screening guidelines. For example, a grantee could support patient navigation in a clinic, such as an FQHC, that serves low-income populations. Grantees must collect CDC-required minimum data elements (MDEs) that are specified in the MDE data dictionary for navigated-only women. When appropriate, navigators should assist in obtaining required patient-level clinical data.



Required Patient Navigation Activities

Although patient navigation services vary based on an individual's needs, at a minimum, patient navigation for women served by the NBCCEDP must include the following activities:

- Assessment of individual patient barriers to cancer screening, diagnostic services, and initiation of cancer treatment
- Patient education and support
- Resolution of patient barriers (e.g., transportation, translation services)
- Patient tracking and follow-up to monitor patient progress in completing screening, diagnostic testing, and initiating cancer treatment
- A minimum of two, but preferably more, contacts with the patient, due to the centrality of the patient-navigator relationship.
- Collection of data to evaluate the primary outcomes of patient navigation -- cancer screening and/or diagnostic testing, final diagnosis, and treatment initiation if needed.

Terminating Patient Navigation

Depending on screening and diagnostic outcomes, patient navigation services are terminated when a client (1) completes screening and has a normal result; (2) completes diagnostic testing and has normal results; (3) initiates cancer treatment; or (4) refuses treatment.

Implementation of Evidence-based Interventions (EBIs)

Grantees should partner with health clinics to increase the overall number of women screened, improving clinic-level breast and cervical cancer screening rates, and strengthen the delivery of cancer screening services. To do this, grantees should partner with health systems to conduct a comprehensive assessment of the partner health care delivery system. The assessment should include breast and cervical cancer screening rates, data/electronic health record (EHR) functionality, patient/health system process flow, policies/standing orders for cancer screening, provider/health system adherence to clinical cancer screening guidelines, patient navigation/community health worker/support services, and use of EBIs or other strategies that support cancer



screening. Grantees, in partnership with the health care system, should use these data to identify priority populations and to identify appropriate interventions for implementation.

By working with health systems, NBCCEDP grantees can expand their reach through implementing EBIs recommended in *The Guide to Community Preventive Services* (aka *The Community Guide*). The following table lists recommended EBIs to increase breast and cervical cancer screenings.

Approach	Intervention*	Breast	Cervical
Increasing Client Demand			
	Client Reminders	Recommended	Recommended
	Group Education	Recommended	Insufficient evidence
	One-On-One Education	Recommended	Recommended
	Small Media	Recommended	Recommended
Increasing Client Access			
	Reducing Structural Barriers	Recommended	Insufficient evidence
	Reducing Out-of-Pocket Costs	Recommended	Insufficient evidence
Increasing Provider Delivery			
	Provider Assessment and Feedback	Recommended	Recommended
	Provider Reminders	Recommended	Recommended

*If an intervention is recommended for one cancer but has insufficient evidence for the other cancer, CDC will allow the intervention to be implemented for both cancers.

The Community Guide also recommends use of interventions from multiple approaches as an effective strategy to increase cancer screening. Research showed that combining EBIs from approaches that increase client demand with those that increase provider delivery or combining EBIs from all three approaches (increasing client demand, increasing client access, and increasing provider delivery) resulted in significant increases in screening among the community compared to the implementation of single EBIs.

Grantees will be required to submit an implementation plan, which is a management tool for planning the implementation EBIs, for each partner health system. Additionally, grantees should work with providers and health systems clinics to strengthen the capability and use of health information technology systems, particularly the EHRs, to 1) monitor clinic-level screening rates, 2) identify populations who need to be screened, 3) implement EBIs, and 4) track completeness and timeliness of screening services.



Description of EBIs

The Community Guide serves as a resource to help select interventions to improve health and prevent disease in your state, community, community organization, business, healthcare organization, or school. The descriptions of EBIs recommended for increasing breast and/or cervical cancer screening are below and can be found at <https://www.thecommunityguide.org/topic/cancer>.

CDC developed individual logic models for all EBIs, patient navigation, and community outreach. An additional ‘meta-logic model’ illustrates how these activities work together to achieve desired outcomes. Grantees are encouraged to use these logic models in designing their own evaluation plans. See [Appendix C](#) for EBI Logic Models.

Client Reminders

Client reminders are written (letter, postcard, email) or telephone messages (including automated messages) advising people that they are due for screening. Client reminders may be enhanced by one or more of the following:

- Follow-up printed or telephone reminders
- Additional text or discussion with information about indications for, benefits of, and ways to overcome barriers to screening
- Assistance in scheduling appointments

These interventions can address the overall target population or tailored with the intent to reach one specific person, based on characteristics unique to that person, related to the outcome of interest, and derived from an individual assessment.

Group Education

Group education conveys information on indications for, benefits of, and ways to overcome barriers to screening with the goal of informing, encouraging, and motivating participants to seek recommended screening. Group education is usually conducted by health professionals or by trained lay people who use presentations or other teaching aids in a lecture or interactive format, and often incorporate role modeling or other methods. Group education can be given to a variety of groups, in different settings, and by different types of educators with different backgrounds and styles.



One-On-One Education

One-on-one education delivers information to individuals about indications for, benefits of, and ways to overcome barriers to cancer screening with the goal of informing, encouraging, and motivating them to seek recommended screening. These messages are delivered by healthcare workers or other health professionals, lay health advisors, or volunteers, and are conducted by telephone or in person in medical, community, worksite, or household settings.

These messages can be untailored to address the overall target population or tailored with the intent to reach one specific person, based on characteristics unique to that person, related to the outcome of interest, and derived from an individual assessment. One-on-one education is often accompanied by supporting materials delivered via small media (e.g., brochures), and may also involve client reminders.

Small Media

Small media include videos and printed materials such as letters, brochures, and newsletters. These materials can be used to inform and motivate people to be screened for cancer. They can provide information tailored to specific individuals or targeted to general audiences.

Grantees should make effort to use existing materials such as [Make It Your Own \(MIYO\)](#) when implementing small media.

Reducing Structural Barriers

Structural barriers are non-economic burdens or obstacles that make it difficult for people to access cancer screening. Interventions designed to reduce these barriers may facilitate access to cancer screening services by:

- Reducing time or distance between service delivery settings and target populations
- Modifying hours of service to meet client needs
- Offering services in alternative or non-clinical settings (e.g., mobile mammography vans at worksites or in residential communities)



- Eliminating or simplifying administrative procedures and other obstacles (e.g., scheduling assistance, patient navigators, transportation, dependent care, translation services, limiting the number of clinic visits)

Such interventions often include one or more secondary supporting measures, such as:

- Printed or telephone reminders
- Education about cancer screening
- Information about screening availability (e.g., group education, pamphlets, or brochures)
- Measures to reduce out-of-pocket costs to the client (though interventions principally designed to reduce client costs are considered to be a separate class of approaches)

Reducing Out-of-Pocket Costs

Interventions to reduce client out-of-pocket costs attempt to minimize or remove economic barriers that make it difficult for clients to access cancer screening services. Costs can be reduced through a variety of approaches, including vouchers, reimbursements, reduction in co-pays, or adjustments in federal or state insurance coverage. Efforts to reduce client costs may be combined with measures to provide client education, information about program availability, or measures to reduce structural barriers.

Provider Assessment and Feedback

Provider assessment and feedback interventions both evaluate provider performance in delivering or offering screening to clients (assessment) and present providers with information about their performance in providing screening services (feedback). Feedback may describe the performance of a group of providers (e.g., mean performance for a practice) or an individual provider, and may be compared with a goal or standard.

***Provider Reminders***

Reminders inform health care providers it is time for a client's cancer screening test (called a "reminder") or that the client is overdue for screening (called a "recall"). The reminders can be provided in different ways, such as in client charts or by e-mail.



Community-Clinical Linkages to Aid Patient Support

Definition

Coordination of services among health systems, communities, and public health using community-based and/or clinic-based health workers can increase access to clinical care and promote health behaviors.

Grantees may use community-based and/or clinic-based health workers/lay advisors, native language speakers, or health educators for community outreach to identify women for screening, provide patient education about risk factors and preventive health behaviors, and address barriers to care. The ultimate goal of the activity is to link women to community resources, medical homes, or health care systems/clinics for cancer screening, diagnostic, genomics, and/or treatment resources. The best way to achieve this is often by working with community and national affiliate partners to reach disparate populations and use culturally appropriate interventions that are tailored for the communities for which they are intended to reach. These health workers may also refer women to health insurance enrollment.

Required Activities

Connecting Women in the Community to Clinical Services

Grantees are required to develop processes to link women to health systems within the community where they live and work. The first steps are to use available data to identify priority disparate populations and/or communities of need and the available resources for that community. Use of community-based workers (lay or professional) can help link women to health systems by providing outreach, education, and/or navigation services.

Grantees should identify and collaborate with key community-based organizations and other community partners that can help reach these disparate populations using culturally appropriate communications and interventions. The organizations may be able to integrate screening messages into their existing outreach, serve as access ports to reach priority women, and assist with referring or navigating women to screening sites. Grantees should develop a Memorandum of Understanding (MOU) with these organizations that clearly defines the activities, roles, and expected outcomes.



The goals of these activities are to

- **Inform** women about the program
- **Educate** women about breast and cervical cancer screening
- **Link** women to health systems to get needed clinical services

Grantees should develop a monitoring and evaluation plan to ensure priority women are identified, linked or navigated to screening, and screened. This may require development of monitoring and tracking tools in conjunction with your partners that can be used to assess the quality and outcomes of all efforts.

Environmental Approaches for Sustainable Cancer Control

Definition

Environmental approaches promote health and support healthy behaviors in states, communities, and smaller settings such as work sites and businesses. Environmental approaches can involve one group or a group of organizations making changes in policies and physical surroundings that makes healthy choices easy, convenient, and affordable for all.

Required Activities

Inform policies that increase access to cancer screening where women live and work

Grantees should use behavior risk factor data, cancer surveillance data, and other available data sources to identify priority communities. This will require engaging community partners such as cancer coalitions and community champions. The focus is to educate and inform employers and community-based organizations in priority communities about ways to help increase breast and cervical cancer screening rates among low-income women by making screening services accessible and facilitating healthy lifestyles that reduce cancer risk. The goal is to have employer and organizational policies in place that increase access to screening and improve health behaviors. Grantees should track policies developed and outcomes of having these policies in place.



Cancer Data and Surveillance

Definition

Data should be utilized for program planning and on-going monitoring of services provided by the program. Use of data is a critical step for all primary strategies (Health System Intervention, Community-Clinical Linkages, and Environmental Approaches). Data can be highly valuable for program monitoring, program improvement, quality assurance and evaluation, as well as for communicating program efforts and successes to the public, legislators, and advocates.

Required activities

Program Planning

Grantees are expected to manage data-driven programs. Identifying, using, and monitoring data should drive program decisions. Grantees should work with researchers, epidemiologists, and others to use current state and local-level data with GIS mapping or other information systems to identify and describe priority populations and/or communities of need. These same data should be reviewed periodically to assess the impact of program activities.

Program Monitoring

The primary outcomes for the NBCCEDP include screening outcomes for women served through the program and screening rates among partner health system clinics. Therefore, grantees are expected to collect, analyze, and report to CDC required patient-level clinical data known as Minimum Data Elements (MDEs) and baseline and annual clinic-level data that includes clinic patient population characteristics and screening rates. See the section on Program Monitoring and Evaluation for more details.

External Partnerships

Definition

Partnerships can be defined as groups of individuals brought together by an established reciprocal agreement for sharing resources and responsibilities to achieve common goals and



derive mutual benefits. The basic assumption of a partnership is that when individuals or organizations join together, they will be more successful in their collective efforts than they could be as individual players. A partnership can be a relationship between as few as two parties, or it can involve a larger number of individuals and organizations.

Required Activities

Partner with organizations to reach priority women

Grantees are expected to develop or continue strategic partnerships in order to support the implementation of cancer program priorities and activities. The purpose of developing partnerships is to help grantees reach their goals by maximizing use of resources and coordinating program activities. To ensure program success, grantees should establish partnerships with entities such as

- Local health care facilities (e.g., community health centers and hospitals)
- Non-traditional agencies (e.g., Bureau of Prisons and the Housing and Urban Development)
- National organization state affiliates (e.g., American Cancer Society and Susan G. Komen)
- Professional organizations
- State and local governments
- Tribal governments
- Tribally designated organizations
- Primary care associations
- Employers
- Non-governmental organizations
- Community advocates.

MOUs, contracts, or some other formal written document must be established with these partners to delineate activities, roles, and expected outcomes. See [Appendix D](#) for MOU requirements.

Grantees should routinely engage partners to monitor progress, provide support, and adjust activities to ensure relationships are yielding desired outcomes.



Program Collaboration

Definition

Collaboration with other cancer and chronic disease programs can improve the reach to the priority population and reduce redundancies. Grantees should work in partnership with other programs to organize and blend interrelated health issues and strategies that increase breast and cervical cancer screening, enhance cancer prevention and risk reduction activities, and decrease cancer burden among NBCCEDP priority populations.

Required Activities

Collaborate with programs that can help achieve cancer control goals

Grantees are required to participate on the Cancer Control Leadership Team to facilitate collaboration across the CDC-funded cancer programs in their catchment area. While tribal programs are not required to submit separate Leadership Plans, they are encouraged to work with their respective state programs.

Key areas of collaboration include:

- Collaboration across the NBCCEDP, the National Comprehensive Cancer Control Program (NCCCP), and the National Program for Cancer Registries (NPCR) as part of the Cancer Leadership Team
- Collaborate with chronic disease and health promotion programs on prevention and risk reduction activities, identifying high-risk populations, informing policies that support cancer prevention and control, and use of public health surveillance data
- Collaborate with central cancer registries for reporting and use of cancer burden data
- Collaborate with cancer registries who collect enhanced screening and clinical data on women diagnosed with breast and cervical cancer
- Collaborate with state cancer coalitions for program planning and identification of priority populations
- Collaborate with immunization programs to disseminate information to women screened through the NBCCEDP about HPV vaccination for adolescents to



prevent cervical cancer and provide referrals to appropriate immunization programs for their children

Program Management

Definition

Program management is the process of leading, facilitating and ensuring the strategic planning, implementation, coordination, integration, and evaluation of programmatic activities and administrative systems to ensure efficiency and effectiveness.

Required activities

Monitor program activities and ensure that all CDC requirements are met

Grantees are expected to:

- Establish and enhance program infrastructure and capacity to increase breast and cervical cancer screening rates and navigation services to priority populations over the length of the project period.
- Hire or retain adequate and qualified staff to manage the program. Essential staff, at the minimum includes 0.5 FTE program director, 0.5 FTE data manager, and 0.5 FTE evaluator.
- Hire staff with adequate knowledge and expertise in health systems interventions and patient navigation.
- Develop an annual work plan containing specific, measureable, achievable, realistic, and time-phased (SMART) objectives as well as activities and performance measures for each program strategy.
- Establish contracts, grants, or memoranda of understanding (MOU) with program partners to assure timely clinical service delivery and implementation of health systems intervention strategies. Copies of MOUs should be submitted to CDC within 90 days of award date.
- Develop and maintain a fiscal system that tracks and monitors program expenditures, ensures the timely reimbursement of services, and provides detailed fiscal reporting to CDC on time.



- Prepare and submit required reports (e.g., annual progress reports and FFRs) and updates (i.e., Quarterly Grantee Update Tool) to CDC on time.
- Develop an evaluation plan with CDC guidance based on program identified strategies. The plan should be updated, as needed, throughout the project period. The plan must include stakeholders, program description, evaluation questions, process/outcome measures, data collection methods, analytic methods, and reporting methods.
- Acquire medical professionals to provide clinical consultation throughout the project period.
- Participate in required CDC meetings and trainings to facilitate the accomplishment of proposed objectives.
- Participate on the state or territorial-wide Cancer Control Leadership Team, that consists of the program directors from the all CDC-funded cancer programs (NBCCEDP, NCCCP, & NPCR).

Role of the Program Director

The program director has a wide range of administrative and program management responsibilities requiring strong leadership abilities and the capability to simultaneously organize and manage multiple tasks. He or she must:

- Recruit and develop a qualified and technically diverse staff
- Demonstrate leadership and communicate effectively with federal and state agency administrators and legislators
- Establish, maintain, and nurture partnerships
- Work with community, local, state, tribal, and national groups and organizations, as well as special interest groups and others
- Develop an annual work plan containing SMART objectives, as well as activities and performance measures for each program component
- Develop an accurate and realistic budget request that corresponds with the program's work plan and meets the administrative requirements and guidelines of the NBCCEDP
- Establish a sound fiscal system that tracks and monitors program expenditures and ensures the accurate and timely reimbursement of services contracted by the program
- Coordinate and manage the operation of all program components



- Anticipate and solve problems
- Negotiate, mediate, and serve as a catalyst for partners, providers, staff members, and others
- Coordinate task forces and work groups on the state and, sometimes, national level
- Participate actively, and make presentations, at national, state, and local meetings and conferences
- Prepare and submit timely required reports.

Program Monitoring and Evaluation

Definition & Purpose

Evaluation, or the systematic collection of information about how a program operates and its impact, is an important part of program management. A good evaluation enables you to monitor program implementation, demonstrate the success of programmatic activity in achieving outcomes, and identify areas for improvement. The purposes of monitoring and evaluation, including performance measurement, and evaluation can be summarized with 3 words: Assess, Demonstrate and Inform.

- **Assess** the extent to which the activities and strategies are successfully implemented by grantees
- **Demonstrate** whether the activities led to expected outputs and to projected outcomes
- **Inform** program planning, decision making, and continuous program quality improvement

Required activities

Assess activities, processes, and progress towards goals

Grantees will be required to:

- Establish and maintain a data system to collect and report to CDC required patient-level clinical data (MDEs) to monitor and track clinical care to ensure high quality screening and diagnostic services are delivered and treatment is



initiated for women diagnosed with cancer, as needed, according to CDC performance indicators (See [Appendix E](#)).

- Use data management systems to monitor whether women navigated complete appropriate screening, diagnostic services, and treatment is initiated, as needed
- Collect and report to CDC required baseline and annual clinic data, including breast and cervical cancer screening rates, from partner health system clinics where the program is implementing EBIs.
- Report success stories to CDC that include strategies, challenges, outcomes, and lessons learned.

Evaluation and Performance Measurement Plan

Grantees must provide an evaluation and performance measurement plan within the first six months of award that demonstrates how the awardee will fulfill the requirements described in the FOA. (See Evaluation section below). Grantees should measure short-term, intermediate, and long-term outcomes. At a minimum the plan must:

- Define the evaluation Purpose(s).
- List stakeholders for the evaluation and their priority areas for evaluation.
- Describe the program using a narrative and including a logic model.
- Describe the type of evaluation to be conducted (i.e. process, outcome, or both).
- List key evaluation questions to be addressed by the evaluation.
- Describe the plan for collecting data, including summary of methods (qualitative and/or quantitative) that align with evaluation questions, and specifying relevant indicators, performance measures, data sources, and who has data collection responsibilities.
- Describe the analysis plan, that is, how the data will be analyzed and how interpretations will be drawn. In particular, describe how evaluation and performance measurements will contribute to our understanding of the advantages and challenges of working collaboratively with health systems and communities.
- Include a dissemination plan that outlines how monitoring data and evaluation results will be reported to stakeholders and used for continuous program quality improvement.
- Provide a timeline for evaluation activities.
- Other information requested as determined by the CDC program.



Data Management Plan

Data management is a process by which required data are acquired, validated, stored, protected, and processed, and by which its accessibility, reliability, and timeliness is ensured to satisfy the needs of the data users. Creating a data management plan ensures the availability of high-quality data for program planning, quality assurance, and evaluation.

A data management plan should include data standards ensuring released data have documentation describing methods of collection, what the data represents, data limitations, and archival and long-term data preservation plans. The data management plan should be submitted as part of the Evaluation and Performance Measurement Plan.

Quality Assurance /Quality Improvement

Quality assurance and quality improvement (QA/QI) support the quality of clinical service delivery. QA is the process of monitoring the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. QI is the commitment and approach used to continuously improve every process in every part of an organization, with the intent of meeting and exceeding customer expectations and outcomes. The QI process can be used to identify and improve any aspect of the program that impedes its function, such as bottlenecks in claims payments, and timely and complete submission of data by providers. QA/QI processes in the NBCCEDP are intended to 1) improve screening and diagnostic services; 2) link structure and process and include standards, measurement, and actions; 3) identify and remedy root causes of quality problems; 4) meet customer needs; and 5) focus on high-volume, costly, high-risk, or problem-prone aspects of care as priorities.

These aims are achieved by assessing performance, making changes based on the assessment, and monitoring improvement. Steps to QA/QI include:

- **Quality monitoring**—The planned, systematic, and ongoing collection, compilation, and organization of data about the quality or appropriateness of an important aspect of care, as well as the comparison of those data to an established level of performance (e.g., target). The NBCCEDP performance



indicators (e.g., timeliness to diagnosis, timeliness to treatment initiation) are designed specifically for this purpose and represent aspects of care that align with the purpose of the NBCCEDP, therefore, are important to monitor.

- **Quality assessment**—The measurement of the level of quality at a given point in time. Assessing quality provides organizations with an opportunity to measure performance against standards (targets or benchmarks). Quality assessment creates a bridge between monitoring and improvement by establishing a common understanding of the quality of services provided and identifying opportunities for improvement. In setting priorities, assessment of clinical services is a key activity. QA above and beyond the NBCCEDP quality indicators (e.g., client satisfaction, screening completion of women navigated) is also encouraged.
- **Quality improvement**—This is the commitment and approach used to improve the process continuously with the intent of meeting and exceeding set expectations and outcomes. QI strives to find strategies that will institute a change and continuously improve quality.

Additionally, it should be noted that activities that ensure quality services must maintain patient confidentiality.



Clinical Services





CLINICAL SERVICES

Clinical Management and Reimbursement Policies for Breast Cancer Assessment

Screening Mammography

The NBCCEDP reimburses for breast cancer screening and diagnostic services provided to low-income (up to 250% FPL) women age 40 and older every 1 to 2 years based on the women's history and clinical presentation. However, the priority population for NBCCEDP mammography services is women between the ages of 50 and 64 and who have no other source of health care reimbursement, such as insurance. Efforts should be concentrated on the priority population. A minimum of 75% of all NBCCEDP-reimbursed screening mammograms provided to average risk women should be to those who are 50 years of age and older.

Breast Cancer Screening for Women at High-Risk

All women should undergo a risk assessment to determine if they are at high risk for breast cancer. NBCCEDP funds can be used for annual breast cancer screening among women who are considered at **high-risk** for breast cancer. "Women at high risk" includes those who have a known genetic mutation such as BRCA 1 or 2, first-degree relatives with premenopausal breast cancer or known genetic mutations, a history of radiation treatment to the chest area before the age of 30 (typically for Hodgkin's lymphoma), and a lifetime risk of 20% or more for development of breast cancer based on risk assessment models that are largely dependent on family history. Providers can choose whichever method they prefer to determine if a woman is at high risk for breast cancer. Women at high risk for breast cancer should be screened with both an annual mammogram and an annual breast MRI.

Breast Cancer Surveillance for Women with History of Breast Cancer

Women who have a known history of breast cancer may be evaluated through the NBCCEDP for surveillance if they meet program eligibility requirements. Follow-up of these women will be



based on their providers assessment and depends on their stage of disease and treatment course. NBCCEDP funds cannot be used to reimburse for any form of treatment.

Breast Cancer Screening for Women 65 Year of Age and Older

If a woman is eligible to receive Medicare benefits and is not enrolled in Medicare, she should be encouraged to enroll. Women enrolled in Medicare Part B are not eligible for the NBCCEDP clinical services. Women who are not eligible to receive Medicare Part B and Medicare-eligible women who cannot pay the premium to enroll in Medicare Part B are eligible to receive mammograms through the NBCCEDP. Mammograms provided to these women will be counted in the 75% minimum.

Breast Cancer Screening for Women Under 40 Years of Age

NBCCEDP funds can be used to evaluate women under the age of 40 who are symptomatic. A woman can be provided a clinical breast examination, diagnostic mammogram, and/or a surgical consultation.

NBCCEDP funds can be used to evaluate asymptomatic women under the age of 40, who have been determined to be at high risk (see above high risk definition) for breast cancer.

Breast Cancer Screening for Transgender Women

Transgender women (male-to-female), who have taken or are taking hormones and meet all program eligibility requirements, are eligible to receive breast cancer screening and diagnostic services through the NBCCEDP. Therefore, federal funds may be used to screen transgender women. While CDC does not make any recommendation about routine screening among this population, grantees and providers should counsel all eligible women, including transgender women, about the benefits and harms of screening and discuss individual risk factors to determine if screening is medically indicated.

The Center of Excellence for Transgender Health and the World Professional Association for Transgender Health have developed consensus recommendations on preventive care services for the transgender population. Those recommendations include “for transwomen with past or current hormone use, breast-screening mammography in patients over age 50 with additional risk factors (e.g., estrogen and progestin use for 5-10 years, positive family history, BMI > 35).”



Those preventive care recommendations can be found at <http://transhealth.ucsf.edu/trans?page=guidelines-breast-cancer-women>.

Breast Cancer Screening for Transgender Men

Transgender men (female-to-male), who have not undergone a bilateral mastectomy and meet all program eligibility requirements, are also eligible to receive breast cancer screening and diagnostic services through the NBCCEDP. Guidance on breast cancer screening for transgender men from the Center of Excellence for Transgender Health can be found at <http://transhealth.ucsf.edu/trans?page=guidelines-breast-cancer-men>.

Breast Cancer Screening for Males

Men are not eligible to receive breast cancer screening and/or diagnostic services through the NBCCEDP.

Mammography Modality

The NBCCEDP will reimburse for film, digital, and 3-D mammography up to the Medicare reimbursement rate. All women should be counseled on the benefits and risks of mammography. If a woman has the option of having a 3-D mammography, she should be counseled on the benefits and risks of 3-D mammograms versus 2-D mammograms to make an informed decision. Grantees should refer to the CDC's CPT Allowable List for appropriate reimbursement CPT codes.

Magnetic Resonance Imaging (MRI)

NBCCEDP will reimburse for screening breast MRI performed in conjunction with a mammogram when a client has a BRCA mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20-25% or greater as defined by risk assessment models. Breast MRI can also be reimbursed when used to better assess areas of concern on a mammogram or for evaluation of a client with a past history of breast cancer after completing treatment. Breast MRI should never be done alone as a breast cancer screening tool. Breast MRI cannot be reimbursed for by the NBCCEDP to assess the extent of disease for staging in women who were recently diagnosed with breast cancer and preparing for treatment. Providers should discuss risk factors with all clients to determine if she is at high risk for breast cancer. To be most effective, it is critical that



breast MRI is done at facilities with dedicated breast MRI equipment and that can perform MRI-guided breast biopsies.

Managing Women with Abnormal Breast Cancer Screening Results

The management of women whose mammogram and/or CBE are abnormal relies on a body of scientific literature that is constantly growing and changing. Grantees are urged to develop clinical policies in close consultation with their medical consultants in consideration of the standards established by such organizations as the National Comprehensive Cancer Network (<http://www.nccn.org/>) and the American College of Radiology (<http://www.acr.org/>).

To arrive at a definitive diagnosis for a woman with an abnormal breast cancer screening test, programs may use NBCCEDP funds to reimburse for ultrasound, mammography-directed biopsy, fine needle aspiration, core biopsy, breast MRI, etc., as well as associated pathology. Grantees are asked to formulate methods by which the use of these procedures may be closely monitored so that they are used appropriately.

Clinical Management and Reimbursement Policies for Cervical Cancer Assessment

The NBCCEDP reimburses for cervical cancer screening and diagnostic services provided to women between the ages of 21 and 64 who are at or below 250% of the federal poverty level and have no other source of health care reimbursement, such as insurance. The priority population includes women who have never been screened. Recruitment efforts should be concentrated on the priority population.

Screening Pap Tests

A minimum of 20% of all NBCCEDP-reimbursed screening Pap tests should be provided to program-eligible women who have never been screened for cervical cancer. Grantees may use either conventional or liquid-based cytology.

Cervical Cancer Screening for Women 21 to 64 Years of Age



The NBCCEDP funds can be used to reimburse for Pap testing alone every 3 years for women aged 21 to 29 years and for Pap testing alone every 3 years, co-testing with the combination of Pap testing with human papillomavirus (HPV) testing every 5 years, or primary HPV testing every 5 years for women aged 30 to 64 years.

NBCCEDP funds can be used for annual cervical cancer screening among women who are considered high-risk (e.g., in-utero DES exposure, immunocompromised such as HIV infection, or history of cervical cancer).

NBCCEDP funds cannot be used to reimburse for cervical cancer screening in women under the age of 21.

Cervical Cancer Screening for Women Over 64 Years of Age

Cervical cancer screening is not recommended for women older than 65 years of age who have had adequate screening and are not high risk. If a woman over 64 needs to be screened and is eligible to receive Medicare benefits but is not enrolled, she should be encouraged to enroll. Women enrolled in Medicare Part B are not eligible for the NBCCEDP clinical services. Women who are not eligible to receive Medicare Part B and Medicare-eligible women who cannot pay the premium to enroll in Medicare Part B are eligible to receive clinical services through the NBCCEDP.

Cervical Cancer Screening for Women at High Risk

Women who are at high risk for cervical cancer need to be screened more frequently than average-risk women. This includes women with HIV infection, who have had an organ transplantation, who may be immunocompromised from another health condition, or who had DES exposure in utero. In general women under the age of 30 should undergo annual Pap testing and women age 30 years and older should have co-testing every 3 years or annual Pap testing.

Cervical Cancer Screening for Transgender Men

Transgender men (female-to-male) who have not undergone a total hysterectomy (i.e., still have a cervix) and meet all other eligibility requirements are eligible to receive cervical cancer screening and diagnostic services through the NBCCEDP.



Cervical Cancer Screening Following Hysterectomy or Other Treatment for Cervical Neoplasia or Cancer

NBCCEDP funds CANNOT be used to reimburse for cervical cancer screening in women who have had total hysterectomies (i.e., those without a cervix), unless the hysterectomy was performed because of cervical neoplasia (precursors to cervical cancer) or invasive cervical cancer.

When a woman concludes her cancer treatment, has been released by her treating physician to return to a schedule of routine screening, and continues to meet NBCCEDP eligibility requirements, she may return to the program and receive all its services.

For women with a history of cervical neoplasia or in situ disease, NBCCEDP funds can be used to reimburse for routine cervical cancer surveillance for 20 years post treatment.

For women with a history of invasive cervical cancer, NBCCEDP funds can be used to reimburse for cervical cancer surveillance indefinitely, as long as they are in good health.

For women whom the reason for the hysterectomy or final diagnosis of no neoplasia or invasive cancer cannot be documented, NBCCEDP funds can be used to reimburse for cervical cancer surveillance. For these women, cervical cancer screening should continue until there is a 10-year history of negative screening results, including the documentation that the Pap tests were technically satisfactory.

If it is unknown if the cervix was removed at the time of the hysterectomy, a physical examination can be done to determine if the cervix is present. NBCCEDP funds can be used to reimburse for an initial examination (i.e., office visit for a pelvic examination) to determine if a woman has a cervix.

Managing Women With Abnormal Cervical Cancer Screening Results

The management of women whose cervical cancer screening tests yield abnormal results relies on a body of scientific literature that is constantly growing and changing. Grantees are urged to develop their clinical policies in close consultation with their medical consultants and in consideration of the standards established by such organizations as the American Society for



Colposcopy and Cervical Pathology (<http://www.asccp.org/asccp-guidelines>), the American College of Obstetricians and Gynecologists (<https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance>), and the Society of Gynecologic Oncologist (<https://www.sgo.org/clinical-practice/guidelines/>).

To arrive at a definitive diagnosis for a woman with an abnormal cervical cancer screening test, programs may use NBCCEDP funds to reimburse for colposcopy, colposcopy-directed biopsy, endocervical curettage, and, in unusual cases, diagnostic excisional procedures (such as LEEP and cold-knife excisions), as well as associated pathology. Grantees are asked to formulate methods by which the use of these procedures may be closely monitored so that they are used appropriately.

Reimbursement of HPV DNA Testing

HPV DNA testing is reimbursable when used for screening or follow-up of abnormal Pap results. HPV genotyping is reimbursable when used for follow-up of abnormal cervical cancer screening results as per ASCCP algorithms. Providers should specify the high-risk HPV DNA panel only. Low-risk HPV DNA panel is not reimbursable.

Adequacy of Follow-up for Women With Abnormal Screening Results

Public Law 101-354 requires programs to take all appropriate measures to ensure the provision of necessary follow-up services required by women who have abnormal screening results and whose clinical services are paid for in whole or in part by NBCCEDP funds. A woman whose breast or cervical cancer screening was abnormal or suspicious must receive appropriate diagnostic procedures to arrive at a final diagnosis. Women with a diagnosis of breast or cervical cancer must be referred for appropriate treatment. Referral should be made to your state Medicaid Treatment Act Program.

Timeliness of Follow-up for Women With Abnormal Screening Results

The interval between abnormal breast cancer screening results and final diagnosis should be 60 days or less. The interval between abnormal cervical cancer results and final diagnosis should be 90 days or less.



Timeliness of Treatment for Women Diagnosed with Cancer

The interval between diagnosis of invasive breast or cervical cancer and initiation of treatment should be 60 days or less.

The interval between diagnosis of cervical intraepithelial neoplasia and initiation of treatment should be 90 days or less.

Tobacco Screening and Cessation

Grantees must develop a policy requiring all participating providers to assess the smoking status of every woman screened by the NBCCEDP and refer those who smoke to tobacco quit lines. As a chronic disease prevention priority, our public health cancer screening programs are able to promote the health of our patients by providing this service with little additional effort.

It is well known that tobacco use is associated with many cancers and chronic diseases that impact the health of our nation. CDC wants to encourage providers to assess all women as a standard of practice, whether or not they are NBCCEDP-paid women. Providers should document assessments and referrals in the client's medical chart. In their annual work plans, each grantee is required to address this requirement.



Data Requirements



DATA REQUIREMENTS

Data systems and related software

CDC provides an optional database known as CaST. The Cancer Screening and Tracking (CaST) system is a database management system used to track women screened for breast and cervical cancer. CaST supports collection of patient-level screening and follow-up data items and allows for the creation of the MDE file that is submitted twice annually to CDC. CaST also helps grantees create linked systems for billing, enrollment, and patient navigation; supports streamlining data entry; and allows for remote data entry via a secured connection and SQL server option. CaST has user defined fields and formats and has the capability to develop queries and reports.

If a grantee chooses to convert their existing data system to a different software package, the grantee is strongly recommended to submit a test data submission to IMS (Information Management Services, CDC's data contractor) for review. The test submission should be completed and submitted well in advance of an MDE submission deadline. CDC strongly recommends that grantees provide a test submission at least one month prior to the standard semi-annual MDE submission. The IMS Technical Consultant should be notified prior to sending the test data. Similarly, it is strongly recommended that revised data forms be sent to CDC and IMS for data management and clinical review prior to finalizing

If you have issues installing or using CaST, you may contact CaSThelp@nbccedp.org or contact your program consultant and IMS technical consultant.

Patient-level Data (Minimum Data Elements)

Minimal Data Elements (MDEs) are a set of standardized data elements used to collect demographic and clinical information on women screened with NBCCEDP funds. The MDEs are reported to CDC twice a year and represent a subset of data required by CDC to monitor screening performance. Each MDE record describes a screening cycle that starts with a screening test and tracks the women through any immediate follow-up of abnormal findings needed to complete diagnostic evaluation and initiate treatment. A unique patient identification



number facilitates tracking screening services to a woman over time. Screening and diagnostic data collected on women reported in the MDEs must meet all data quality standards set by CDC.

The MDEs include screening and/or diagnostic data for program-eligible women in any of the following scenarios:

- Screening and/or diagnostic testing solely paid for by NBCCEDP funds
- Screening and/or diagnostic testing paid for in part by NBCCEDP funds and other funding sources (e.g., state, private, or other federal funds) with the ability to distinguish the funds contributed by the NBCCEDP
- Patient-navigation only services paid for by NBCCEDP funds and screening and/or diagnostic testing paid solely by other funding source. Grantees will report an abbreviated MDE record in this scenario.

Data linkages with Central Cancer Registry

Grantees are required to perform data linkages with the state central cancer registry in accordance with CDC specifications, to enhance the completeness and quality of MDEs and registry data systems. Results from the linkages should be used to update the MDEs with registry-standardized diagnosis and stage data, identify missing cancer cases in the central cancer registry, and reconcile differences between the two data sources. Linkage requirements and procedures will be provided to grantees as registry data is updated.

Clinic-level data

Grantees will submit baseline and annual clinic data for each partner health system clinic where EBIs are implemented. Data elements include unique health system and clinic IDs that allows for tracking over time, health system and clinic characteristics; patient population demographics; clinic partnership status; screening rates; monitoring and quality improvement activities; EBI implementation; patient navigation; and strategies for supporting community clinical linkages (e.g., community health work). Grantees can use optional Baseline and Annual Clinic Data Collection Forms to collect and compile relevant clinic data elements. CDC has developed guidance documents and data dictionaries for measuring clinic-level screening rates. See [Appendix F](#) for the list of the required clinic data elements. See [Appendix G](#) for tables from the guidance document on measuring breast and cervical cancer screening rates.



Grantees will collect baseline clinic data for all partner clinics prior to implementing program activities (i.e., EBIs). Grantees will submit clinic data via the online Breast and Cervical Clinic-Based Annual Reporting System (B&C-BARS). Each year grantees will submit annual clinic data for each partner clinic. Performance on EBI-related health system change will be measured by these data. This measurement includes assessing changes in clinic-level screening rates and EBI implementation.

Grantee survey

The annual NBCCEDP grantee survey will collect additional information on program management, clinic service delivery, partnerships, provider networks, and program challenges. The survey is administered electronically each July. Survey data will be used to describe grantee programs and to inform CDC about training/technical assistance needs of grantees.

Data Sharing and Approvals

As part of the IRB agreement for collection and analysis of data elements from the NBCCEDP, CDC maintains a data sharing policy regarding requests for MDE data for research use by CDC or external investigators. Data requests must include a research proposal which is subject to requirements of confidentiality, human subject's protection, and clearance procedures. Proposals are reviewed and approved through CDC's MDE committee. The policy calls for the removal of personal identifiers and geographic indicators to provide "national level" data. Other than the program-specific data presented on CDC's public web site, which is provided so residents can view statistics for their state, CDC does not release program-specific data for use outside of CDC without notifying the program. This policy does not apply to data inquiries from the Office of Management and Budget (OMB), Congress, or similar entities, or to aggregate data shared with the general public to describe results of the NBCCEDP. CDC also maintains approval from OMB to collect the described data elements. CDC's legal counsel has determined that MDE data are subject to the Freedom of Information Act.



CDC Monitoring and Accountability Approach





CDC MONITORING AND ACCOUNTABILITY APPROACH

Monitoring activities will include routine and ongoing communication between the CDC and grantee, site visits, and grantee reporting [including work plans, evaluation plans, data reporting (i.e., MDE, clinic data, grantee survey), and financial reporting]. These activities provide the CDC with periodic data to examine grantees' overall performance and progress toward meeting the NBCCEDP goals and outcomes. Reporting identifies successes and challenges that grantees encounter throughout the project period. Reporting is a requirement for awardees who want to apply for yearly continuation of funding.

To assess and support grantee performance, CDC will:

- **review** work plans and screening projections to ensure feasibility based on the budget and consistency with the requirements of the funding opportunity announcement.
- **confirm** that grantees are performing at a satisfactory level to achieve outcomes within stated timeframes.
- **work** with grantees to adjust work plans, budgets, and other application materials based on achievement of outcomes, evaluation results, and final award.
- **monitor** data, including performance measures (programmatic and financial), to assure satisfactory performance levels.
- **monitor** and report consistency with grant regulations and policies along with the identification, notification, and management of financial issues.

Workplan

CDC requires NBCCEDP grantees to develop annual work plans to assist in planning a course of action for the coming year, guided by national program goals and based on individual program needs and resources. The work plan is a management tool that provides direction and guidance for the overall program as well as for each program component; it can serve as a blueprint for program management. It should include SMART objectives for each program component ([See Appendix H](#)). The essential elements for each program component should be addressed in the program's work plan. The work plan also should list the staff members who are responsible for each activity and include a description of the evaluation measures to determine the program's progress toward achieving objectives. These evaluation measures should include specific time



intervals for reviewing progress. Programs are encouraged to use the NBCCEDP work plan template as a guide for developing their individual work plans (See [Appendix I](#)).

Work plans have the following components:

- Goals
- Measures of success
- Measurable objectives
- Activities
- Data
- Timeframe for assessing progress
- Team members responsible
- Progress report

Grantees can use work plans to do the following:

- State the goals and objectives of each program component and the strategies that will be used to attain them
- Help the staff members who are responsible for different program components determine priorities for planning and a timeline for implementation
- Help align program objectives and activities with the budget request
- Provide a template for organizing and monitoring the program implementation process
- Establish measures of success by which to gauge program effectiveness
- Provide a mechanism for making revisions as a result of progress and deficiencies
- Assist with training key staff members to plan, implement, monitor progress, and assess program activities

Health System EBI Implementation Plan

Grantees are required to develop an implementation plan for each partner health system where EBIs will be implemented. The NBCCEDP Health System EBI Implementation Plan is a management tool for planning the implementation of EBIs within partner health system clinics. This plan should be completed in collaboration with each partner health system. The plan is intended to promote program success by ensuring rigorous assessment and planning in the selection of priority EBIs and supporting strategies. A well-constructed Health System EBI Implementation Plan demonstrates readiness for implementation and likelihood of achieving



outcomes. Grantees must submit Health System EBI Implementation Plans to your CDC program consultant for review and approval **prior** to implementing EBIs in the respective health system. At least one plan is required during Program Year 2017-2018. Grantees may submit more than one implementation plan as appropriate.

CDC has developed a Health System EBI Implementation Plan template that you may use ([See Appendix J](#)). Required information in the plan includes:

- Date of Health System EBI Implementation Plan
- Partner health system name and point of contact
- Implementation time period and number of clinics participating in NBCCEDP implementation
- Description of assessment activities conducted and assessment findings (e.g., health system context; NBCCEDP policies/activities currently in place; health system needs; potential barriers/challenges to implementation; resources available)
- Intervention plan (e.g., objectives; EBIs and supportive activities to be implemented)
- Management plan, including planned program monitoring efforts (e.g., communications plan; implementation support, including persons responsible for this support; process for monitoring implementation of EBIs/supporting activities; sustainability efforts).



NBCCEDP Legislative Requirements



NBCCEDP LEGISLATIVE REQUIREMENTS

Matching Funds

Recipient financial participation is required for this program in accordance with the authorizing legislation. Section 1502(a) and (b)(1), (2), and (3) of the Public Health Services (PHS) Act, as amended, requires matching funds from non-Federal sources in an amount not less than one dollar for every three dollars of Federal funds awarded under this program. However, Title 48 of the U.S. Code 1469a (d) requires DHHS to waive matching fund requirements up to \$200,000 for Guam, U.S. Virgin Islands, American Samoa and the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

Matching funds may be cash, in-kind or donated services or equipment. Contributions may be made directly or through donations from public or private entities. Public Law 93-638 authorizes tribal organizations contracting under the authority of Title I to use funds received under the Indian Self-Determination Act as matching funds.

Applicants may also designate as State/Tribal/Territorial/Pacific Island Jurisdiction matching funds any non-Federal amounts spent pursuant to Title XIX of the Social Security Act for the screening and case management of women for breast and cervical cancers.

Matching funds may not include: (1) payment for treatment services or the donation of treatment services; (2) services assisted or subsidized by the Federal government; or (3) the indirect or overhead costs of an organization. All costs used to satisfy the matching requirements must be documented by the applicant and will be subject to audit.

Maintenance of Effort

Maintenance of Effort is required for this program in accordance with the authorizing legislation PL 101-354. The average amount of non-Federal contributions toward breast and cervical cancer programs and activities for the two year period preceding the first Federal fiscal year of funding for NBCCEDP is referred to as Maintenance of Effort (MOE). Only those non-Federal contributions in excess of the MOE amount may be considered matching funds. Supplanting, or replacing, existing program efforts currently paid with Federal or non-Federal sources is not allowable.



Non-federal Medicaid amounts are allowable as sources of matching funds. However, the State Medicaid contribution is subject to the maintenance-of-effort requirement, must be program related, and cannot be used for any other program.

Medicare reimbursement rate for screening and diagnostic services

The amount paid by a program to an entity for screening and follow-up services may not exceed the amount that would be paid under Part B of title XVIII of the Social Security Act (maximum Medicare rates in the State).

For each of the screening and diagnostic services paid for by the NBCCEDP, the program may choose to reimburse providers at either a single rate based on the Medicare rates approved by the Center for Medicare and Medicaid Services (CMS) for that State or using multiple rates, such as a single urban rate, a single rural rate, or the various regional Medicare rates approved by CMS.

10% administrative costs

No more than 10% of the federal monies may be used for administrative expenses. The total dollar amount of federal monies awarded to the program should be used as the basis for determining the 10% administrative costs. The 10% limitation on administrative costs is in lieu of indirect costs. Each program may define the basis for its administrative costs. However, administrative expenses (i.e., indirect costs) associated with all contracts are considered part of the limitation placed on the overall total administrative costs under the cooperative agreement award.

Payor of last resort (except for IHS)

NBCCEDP funds cannot be used to pay for any service for which payment has been made or can be made by a State compensation program, under an insurance policy, under a federal or state health benefits program, or by an entity that provides health services on a prepaid basis. This use of NBCCEDP funds only after all other sources have been exhausted means that the NBCCEDP is the “payor of last resort.”



The exception to this rule is clinics or offices that are operated by Indian Health Service (IHS) or individual American Indian tribes. IHS is the payor of last resort for persons who have an alternate resource (42 CFR 136.61 [2002]); the NBCCEDP has historically been considered such an alternative resource.

Restrictions on use of grant funding

Other legal requirements of programs include the following stipulations:

- NBCCEDP funds may not be used to provide inpatient hospital services for any individual.
- Grantees must agree to give priority to low-income women in their provision of program services.
- Imposition of fees for services must be limited.
- Program services must be available to women throughout the state, tribe, or territory.
- Program activities must be coordinated with other federal, state, tribal, and local programs operating in the jurisdiction.
- Grantees must establish fiscal control and fund accounting procedures that are subject to audit.
- NBCCEDP funds may not be used for research.
- NBCCEDP funds may not be used for any lobbying activity to influence or induce members of the public to contact their elected representatives to influence support or opposition to proposed or pending legislation.

Notice of Awards (NOA)

In addition to the legislative requirements detailed above, a grantee's activities are governed by the provisions of its official NOA. Programs are subject to any terms and conditions noted in the NOA, as well as the Public Health Services (PHS) grants policy statements that are in effect as of the beginning of the budget period. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system. Grantees should follow the terms outlined in the NOA regarding reporting requirements and approval processes. For questions regarding the grants management process, grantees should contact the Grants Management Specialist in CDC's Office of Grants Services.



Appendices





Appendix A: Public Law 101-354 and Its Amendments (P.L. 103-183 and P.L. 105-340)

Title 42. The Public Health and Welfare
Chapter 6a. The Public Health Service
Preventive Health Measures With Respect to Breast and Cervical Cancers
42 U.S.C. § 300k

Note: Amendments to Public Law 101-354 are indicated in bold and italics, followed by a reference to the amending law in parentheses.

§ 300k. Establishment of program of grants to States

(a) In general. The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to States on the basis of an established competitive review process for the purpose of carrying out programs—

- (1) to screen women for breast and cervical cancer as a preventive health measure;
- (2) to provide appropriate referrals for medical treatment of women screened pursuant to paragraph (1) and to ensure, to the extent practicable, the provision of appropriate follow-up services ***and support services such as case management (Women's Health Research and Prevention Amendments of 1998, Public Law 105-340)***;
- (3) to develop and disseminate public information and education programs for the detection and control of breast and cervical cancer;
- (4) to improve the education, training, and skills of health professionals (including allied health professionals) in the detection and control of breast and cervical cancer;
- (5) to establish mechanisms through which the States can monitor the quality of screening procedures for breast and cervical cancer, including the interpretation of such procedures; and
- (6) to evaluate activities conducted under paragraphs (1) through (5) through appropriate surveillance or program-monitoring activities.

(b) Grant and contract authority of States.

- (1) In general. A State receiving a grant under subsection (a) may, subject to paragraphs (2) and (3), expend the grant to carry out the purpose described in such subsection ***through grants to public and nonprofit private entities and through contracts with public and private entities (Women's Health Research and Prevention Amendments of 1998, Public Law 105-340)***.



(2) Certain applications. If a nonprofit private entity and a private entity that is not a nonprofit entity both submit applications to a State to receive an award of a grant or contract pursuant to paragraph (1), the State may give priority to the application submitted by the nonprofit private entity in any case in which the State determines that the quality of such application is equivalent to the quality of the application submitted by the other private entity (Women's Health Research and Prevention Amendments of 1998, Public Law 105-340).

(3) Payments for screenings. The amount paid by a State to an entity under this subsection for a screening procedure under subsection (a)(1) may not exceed the amount that would be paid under part B of title XVIII of the Social Security Act [42 U.S.C. §§ 1395j et seq.] if payment were made under such part for furnishing the procedure to a woman enrolled under such part.

(c) Special consideration for certain States. In making grants under subsection (a) to States whose initial grants under such subsection are made for fiscal year 1995 or any subsequent fiscal year, the Secretary shall give special consideration to any State whose proposal for carrying out programs under such subsection—

- (1) has been approved through a process of peer review; and
- (2) is made with respect to geographic areas in which there is—
 - (A) a substantial rate of mortality from breast or cervical cancer; or
 - (B) a substantial incidence of either of such cancers.

[(d)](c) Coordinating committee regarding year 2000 health objectives. The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a committee to coordinate the activities of the agencies of the Public Health Service (and other appropriate federal agencies) that are carried out toward achieving the objectives established by the Secretary for reductions in the rate of mortality from breast and cervical cancer in the United States by the year 2000. Such committee shall be comprised of federal officers or employees designated by the heads of the agencies involved to serve on the committee as representatives of the agencies, and such representatives from other public or private entities as the Secretary determines to be appropriate.

§ 300I. Requirement of matching funds

(a) In general. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees, with respect to the costs to be incurred by the State in carrying out the purpose described in such section, to make available non-federal contributions (in cash or in kind under subsection (b)) toward such costs in an amount equal to not less than \$1 for each \$3 of federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities.

(b) Determination of amount of non-federal contribution.

- (1) In general. Non-federal contributions required in subsection (a) may be in cash or in kind, fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the federal government, or services assisted or



subsidized to any significant extent by the federal government, may not be included in determining the amount of such non-federal contributions.

(2) Maintenance of effort. In making a determination of the amount of non-federal contributions for purposes of subsection (a), the Secretary may include only non-federal contributions in excess of the average amount of non-federal contributions made by the State involved toward the purpose described in section 1501 [42 U.S.C. § 300k] for the 2-year period preceding the first fiscal year for which the State is applying to receive a grant under such section.

(3) Inclusion of relevant non-federal contributions for Medicaid. In making a determination of the amount of non-federal contributions for purposes of subsection (a), the Secretary shall, subject to paragraphs (1) and (2) of this subsection, include any non-federal amounts expended pursuant to title XIX of the Social Security Act [42 U.S.C. § 1396 et seq.] by the State involved toward the purpose described in paragraphs (1) and (2) of section 1501(a) [42 U.S.C. § 300k(a)].

§ 300l-1. Requirement regarding Medicaid

The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] for a program in a State unless the State plan under title XIX of the Social Security Act [42 U.S.C. §§ 1396 et seq.] for the State includes the screening procedures specified in subparagraphs (A) and (B) of section 1503(a)(2) [42 U.S.C. § 300m(a)(2)(A), (B)] as medical assistance provided under the plan.

§ 300m. Requirements with respect to type and quality of services

(a) Requirement of provision of all services by date certain. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees—

(1) to ensure that, initially and throughout the period during which amounts are received pursuant to the grant, not less than 60 percent of the grant is expended to provide each of the services or activities described in paragraphs (1) and (2) of section 1501(a) [42 U.S.C. § 300k(a)], including making available screening procedures for both breast and cervical cancers;

(2) subject to subsection (b), to ensure that—

(A) in the case of breast cancer, both a physical examination of the breasts and the screening procedure known as a mammography are conducted; and

(B) in the case of cervical cancer, both a pelvic examination and the screening procedure known as a Pap smear are conducted;

(3) to ensure that, by the end of any second fiscal year of payments pursuant to the grant, each of the services or activities described in section 1501(a) [42 U.S.C. § 300k(a)] is provided; and

(4) to ensure that not more than 40 percent of the grant is expended to provide the services or activities described in paragraphs (3) through (6) of such section.

(b) Use of improved screening procedures. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that, if any screening procedure superior to a procedure described in subsection (a)(2) becomes commonly available and is



recommended for use, any entity providing screening procedures pursuant to the grant will utilize the superior procedure rather than the procedure described in such subsection.

(c) Quality assurance regarding screening procedures. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that the State will, in accordance with applicable law, assure the quality of screening procedures conducted pursuant to such section

(Preventive Health Amendments of 1993, Public Law 103-183).

§ 300n. Additional required agreements

(a) Priority for low-income women. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that low-income women will be given priority in the provision of services and activities pursuant to paragraphs (1) and (2) of section 1501(a) [42 U.S.C. § 300k(a)].

(b) Limitation on imposition of fees for services. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that, if a charge is imposed for the provision of services or activities under the grant, such charge—

- (1) will be made according to a schedule of charges that is made available to the public;
- (2) will be adjusted to reflect the income of the woman involved; and
- (3) will not be imposed on any woman with an income of less than 100 percent of the official poverty line, as established by the Director of the Office of Management and Budget and revised by the Secretary in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981 [42 U.S.C. § 9902(2)].

(c) Statewide provision of services.

(1) In general. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that services and activities under the grant will be made available throughout the State, including availability to members of any Indian tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act [25 U.S.C. § 450b]).

(2) Waiver. The Secretary may waive the requirement established in paragraph (1) for a State if the Secretary determines that compliance by the State with the requirement would result in an inefficient allocation of resources with respect to carrying out the purpose described in section 1501(a) [42 U.S.C. § 300k(a)].

(3) Grants to tribes and tribal organizations.

(A) The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to tribes and tribal organizations (as such terms are used in paragraph (1)) for the purpose of carrying out programs described in section 1501(a) [42 U.S.C. § 300k(a)]. This title applies to such a grant (in relation to the jurisdiction of the tribe or organization) to the same extent and in the same manner as such title applies to a grant to a State under section 1501 [42 U.S.C. § 300k] (in relation to the jurisdiction of the State).

(B) If a tribe or tribal organization is receiving a grant under subparagraph (A) and the State in which the tribe or organization is located is receiving a grant



under section 1501 [42 U.S.C. § 300k], the requirement established in paragraph (1) for the State regarding the tribe or organization is deemed to have been waived under paragraph (2) (***Preventive Health Amendments of 1993, Public Law 103-183***).

(d) Relationship to items and services under other programs. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that the grant will not be expended to make payment for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to such item or service—

- (1) under any State compensation program, under an insurance policy, or under any federal or state health benefits program; or
- (2) by an entity that provides health services on a prepaid basis.

(e) Coordination with other breast and cervical cancer programs. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that the services and activities funded through the grant shall be coordinated with other Federal, State, and local breast and cervical cancer programs.

(f) Limitation on administrative expenses. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that not more than 10 percent of the grant will be expended for administrative expenses with respect to the grant.

(g) Restrictions on use of grant. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that the grant will not be expended to provide inpatient hospital services for any individual.

(h) Records and audits. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that—

- (1) the State will establish such fiscal control and fund accounting procedures as may be necessary to ensure the proper disbursement of, and accounting for, amounts received by the State under such section; and
- (2) upon request, the State will provide records maintained pursuant to paragraph (1) to the Secretary or the Comptroller of the United States for purposes of auditing the expenditures by the State of the grant.

(i) Reports to Secretary. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees to submit to the Secretary such reports as the Secretary may require with respect to the grant.

§ 300n-1. Description of intended uses of grant

The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless—

- (1) the State involved submits to the Secretary a description of the purposes for which the State intends to expend the grant;
- (2) the description identifies the populations, areas, and localities in the State with a need for the services or activities described in section 1501(a) [42 U.S.C. § 300k(a)];



(3) the description provides information relating to the services and activities to be provided, including a description of the manner in which the services and activities will be coordinated with any similar services or activities of public and nonprofit private entities; and

(4) the description provides assurances that the grant funds will be used in the most cost-effective manner.

§ 300n-2. Requirement of submission of application

The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless an application for the grant is submitted to the Secretary, the application contains the description of intended uses required in section 1505 [42 U.S.C. § 300n-1], and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this title [42 U.S.C. §§ 300k et seq.].

§ 300n-3. Technical assistance and provision of supplies and services in lieu of grant funds

(a) Technical assistance. The Secretary may provide training and technical assistance with respect to the planning, development, and operation of any program or service carried out pursuant to section 1501 [42 U.S.C. § 300k]. The Secretary may provide such technical assistance directly or through grants to, or contracts with, public and private entities.

(b) Provision of supplies and services in lieu of grant funds.

(1) In general. Upon the request of a State receiving a grant under section 1501 [42 U.S.C. § 300k], the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the State in carrying out such section and, for such purpose, may detail to the State any officer or employee of the Department of Health and Human Services.

(2) Corresponding reduction in payments. With respect to a request described in paragraph (1), the Secretary shall reduce the amount of payments under the grant under section 1501 [42 U.S.C. § 300k] to the State involved by an amount equal to the costs of detailing personnel (including pay, allowances, and travel expenses) and the fair market value of any supplies, equipment, or services provided by the Secretary. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

§ 300n-4. Evaluations and reports

(a) Evaluations. The Secretary shall, directly or through contracts with public or private entities, provide for annual evaluations of programs carried out pursuant to section 1501 [42 U.S.C. § 300k]. Such evaluations shall include evaluations of the extent to which States carrying out such programs are in compliance with section 1501(a)(2) [42 U.S.C. § 300k(a)(2)] and with section 1504(c) [42 U.S.C. § 300n(c)].

(b) Report to Congress. The Secretary shall, not later than 1 year after the date on which amounts are first appropriated pursuant to section 1509(a) [42 U.S.C. § 300n-5(a)], and annually



thereafter, submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report summarizing evaluations carried out pursuant to subsection (a) during the preceding fiscal year and making such recommendations for administrative and legislative initiatives with respect to this title [42 U.S.C. §§ 300k et seq.] as the Secretary determines to be appropriate, including recommendations regarding compliance by the States with section 1501(a)(2) [42 U.S.C. § 300k(a)(2)] and with section 1504(c) [42 U.S.C. § 300n(c)].

§ 300n-4a. Supplemental grants for additional preventive health services

(a) Demonstration projects. In the case of States receiving grants under section 1501 [42 U.S.C. § 300k], the Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to not more than 3 such States to carry out demonstration projects for the purpose of—

- (1) providing preventive health services in addition to the services authorized in such section, including screenings regarding blood pressure and cholesterol, and including health education;
- (2) providing appropriate referrals for medical treatment of women receiving services pursuant to paragraph (1) and ensuring, to the extent practicable, the provision of appropriate follow-up services; and
- (3) evaluating activities conducted under paragraphs (1) and (2) through appropriate surveillance or program-monitoring activities.

(b) Status as participant in program regarding breast and cervical cancer. The Secretary may not make a grant under subsection (a) unless the State involved agrees that services under the grant will be provided only through entities that are screening women for breast or cervical cancer pursuant to a grant under section 1501 [42 U.S.C. § 300k].

(c) Applicability of provisions of general program. This title [42 U.S.C. §§ 300k et seq.] applies to a grant under subsection (a) to the same extent and in the same manner as such title applies to a grant under section 1501 [42 U.S.C. § 300k].

(d) Funding.

- (1) In general. Subject to paragraph (2), for the purpose of carrying out this section, there are authorized to be appropriated \$3,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 ***through 2003 (Women's Health Research and Prevention Amendments of 1998, Public Law 105-340)***.
- (2) Limitation regarding funding with respect to breast and cervical cancer. The authorization of appropriations established in paragraph (1) is not effective for a fiscal year unless the amount appropriated under section 1510(a) [42 U.S.C. § 300n-5(a)] for the fiscal year is equal to or greater than \$100,000,000.

§ 300n-5. Funding for general program

(a) Authorization of appropriations. For the purpose of carrying out this title [42 U.S.C. §§ 300k et seq.], there are authorized to be appropriated \$50,000,000 for fiscal year 1991, such sums as

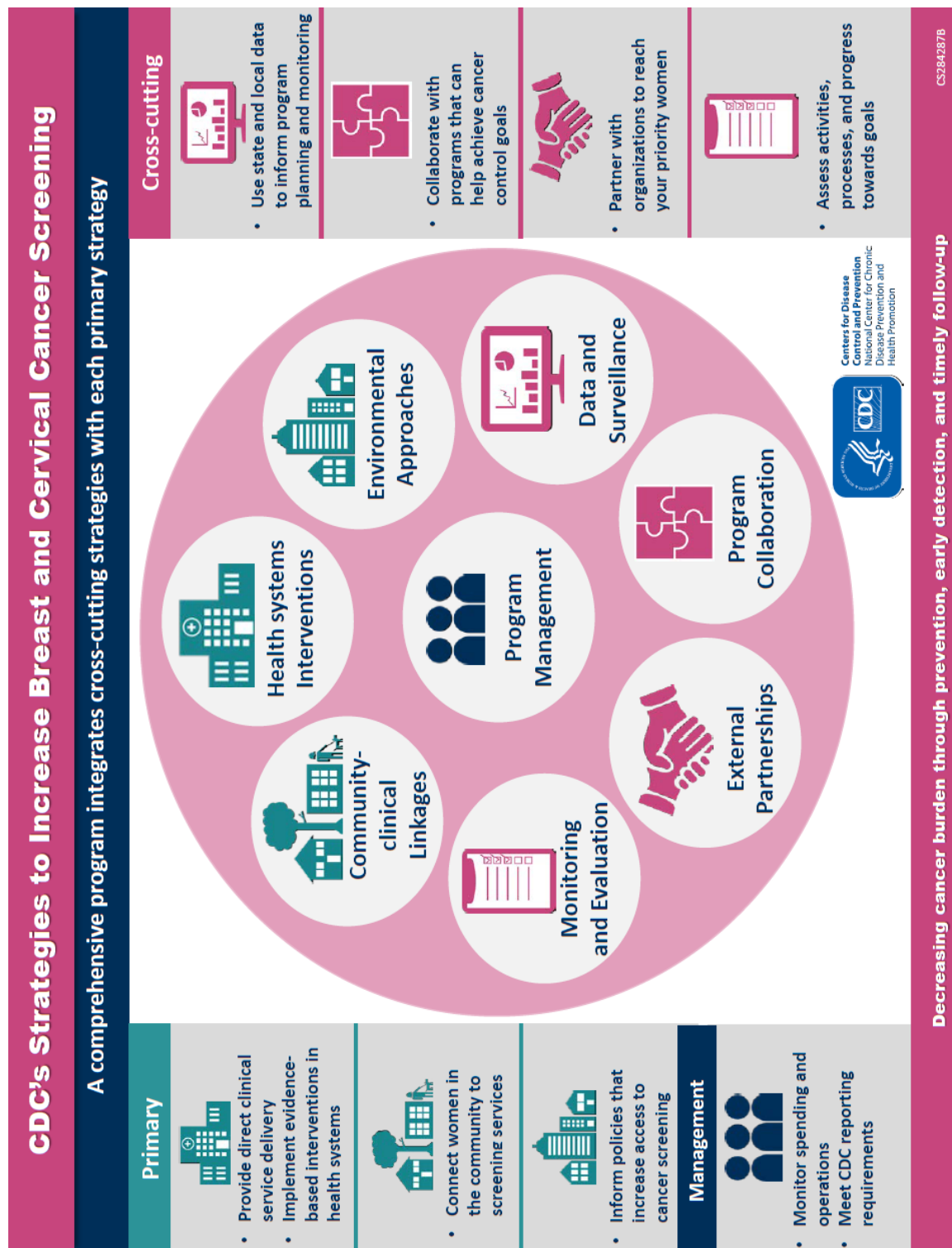


may be necessary for each of the fiscal years 1992 and 1993, \$150,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 ***through 2003 (Women's Health Research and Prevention Amendments of 1998, Public Law 105-340)***.

(b) Set-aside for technical assistance and provision of supplies and services. Of the amounts appropriated under subsection (a) for a fiscal year, the Secretary shall reserve not more than 20 percent for carrying out section 1507 [42 U.S.C. § 300n-3].

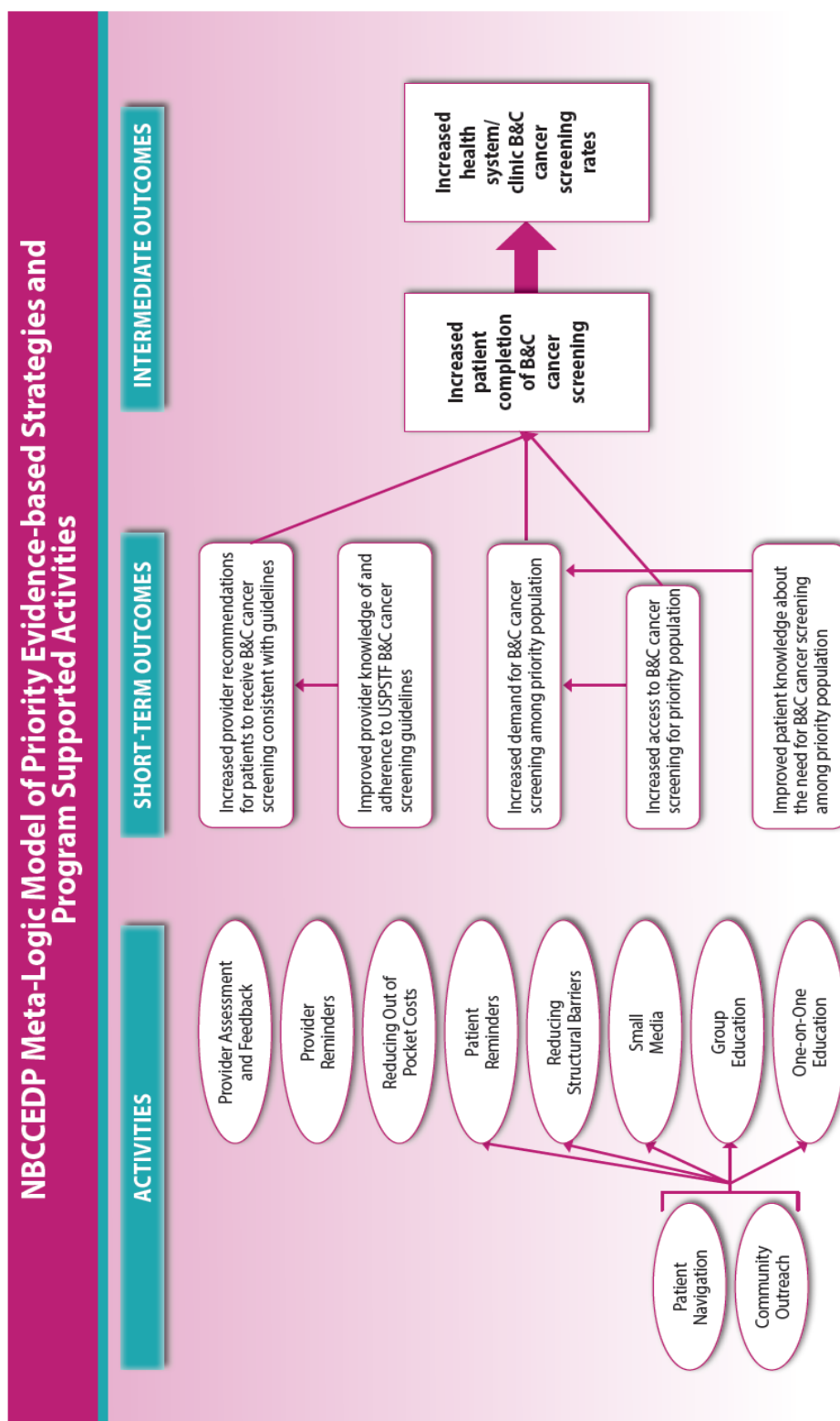


Appendix B: CDC's Strategies to Increase Breast and Cervical Cancer Screening





Appendix C: Evidence-based Interventions Logic Models



Definitions/Abbreviations

USPSTF = United States Preventive Services Task Force
 MIYO = "Make It Your Own" www.miyoworks.org
 Research-tested messages and designs for health communications materials

EMR = Electronic Medical Records
 PN = Patient Navigation
 CHWs = Community Health Workers

August 2017

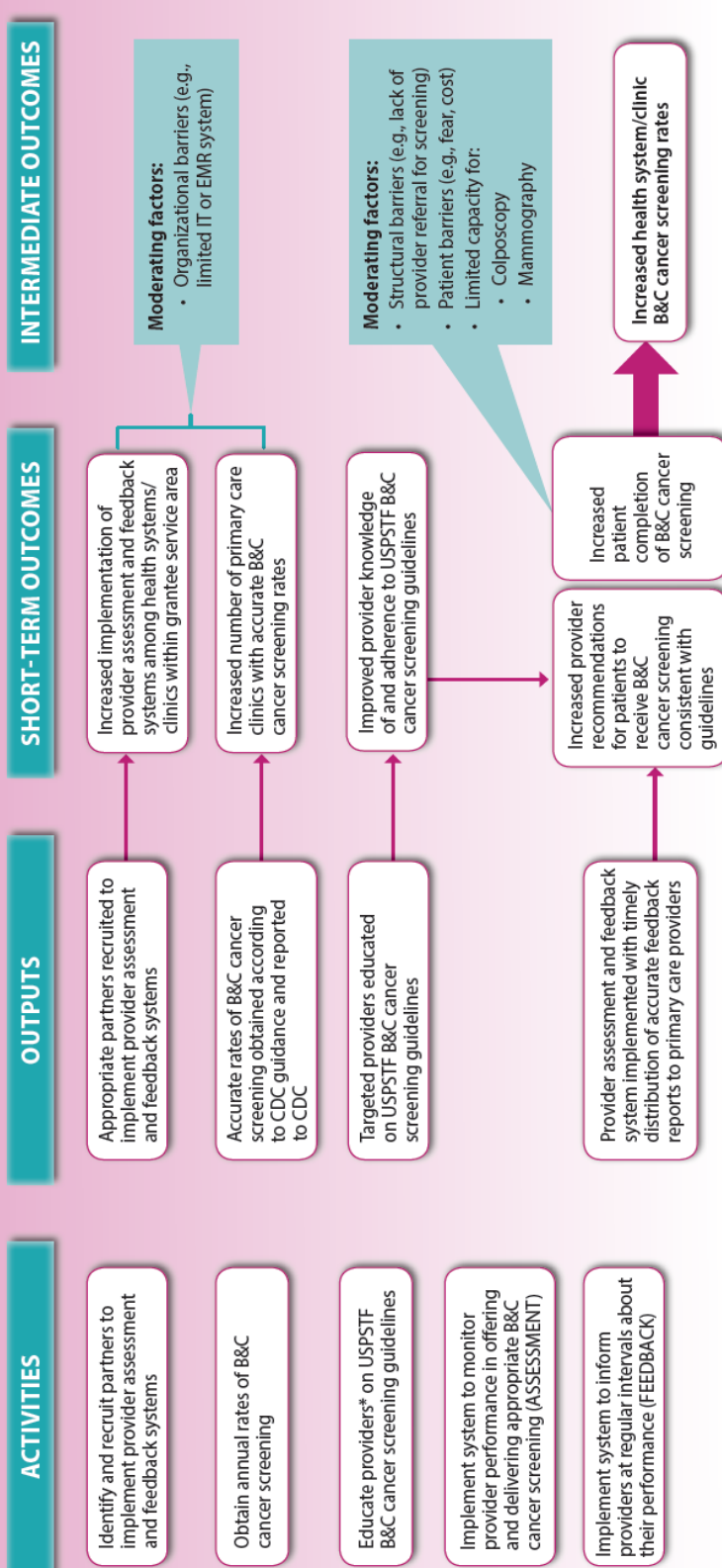


CS3462-8



Provider Assessment and Feedback for the NBCCEDP – Logic Model

EVIDENCE-BASED STRATEGY



*The term "providers" refers to any/all clinical staff involved in implementation/use of the provider assessment and feedback system.

Monitoring and Evaluation by Grantee

Definitions/Abbreviations

USPSTF = United States Preventive Services Task Force
 MHO = "Make It Your Own" www.mho.org
 Research-tested messages and designs for health communications materials

EMR = Electronic Medical Records
 PN = Patient Navigation
 CHWs = Community Health Workers

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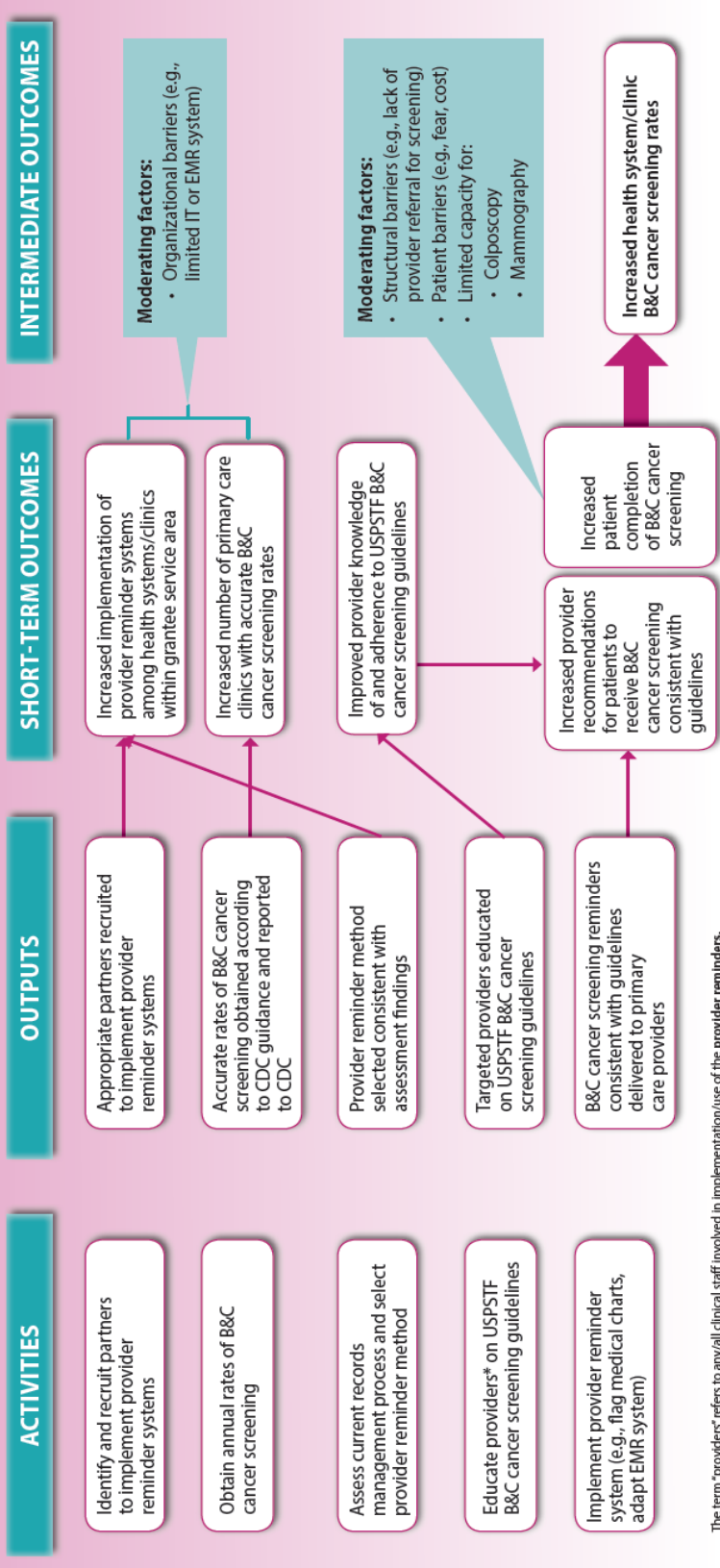
Centers for Disease Control and Prevention
 National Cancer Institute
 Division of Cancer Prevention and Control
 National Cancer Institute
 Division of Cancer Prevention and Control

CDC/NCI/DP17-1701



Provider Reminders for the NBCCEDP – Logic Model

EVIDENCE-BASED STRATEGY



Monitoring and Evaluation by Grantee

Definitions/Abbreviations

USPSTF = United States Preventive Services Task Force
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 Research-tested messages and designs for health communications materials

EMR = Electronic Medical Records
 PN = Patient Navigation
 CHWs = Community Health Workers

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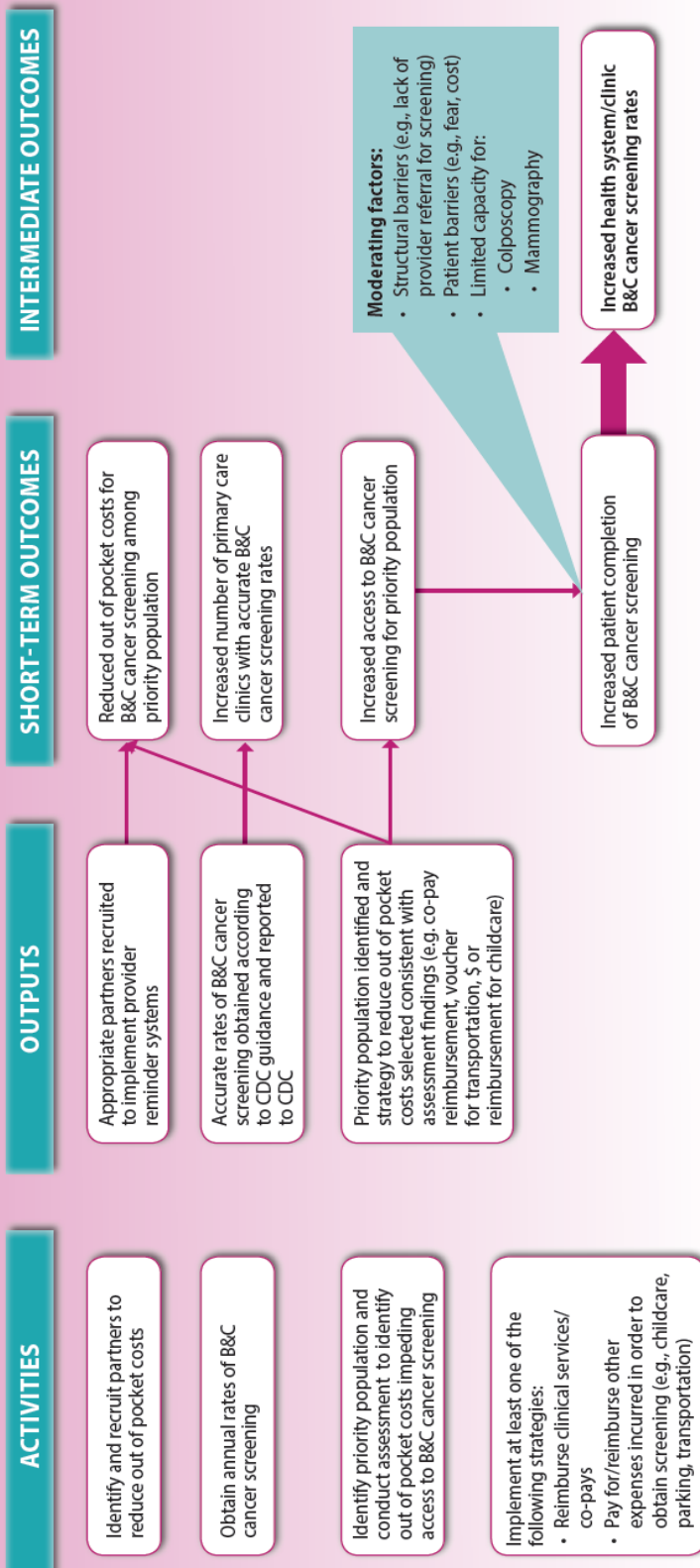
Centers for Disease Control and Prevention
 National Center for Chronic Disease Prevention and Health Promotion

CDCNCE-8



Reducing Out of Pocket Costs for the NBCCEDP – Logic Model

EVIDENCE-BASED STRATEGY



Monitoring and Evaluation by Grantee

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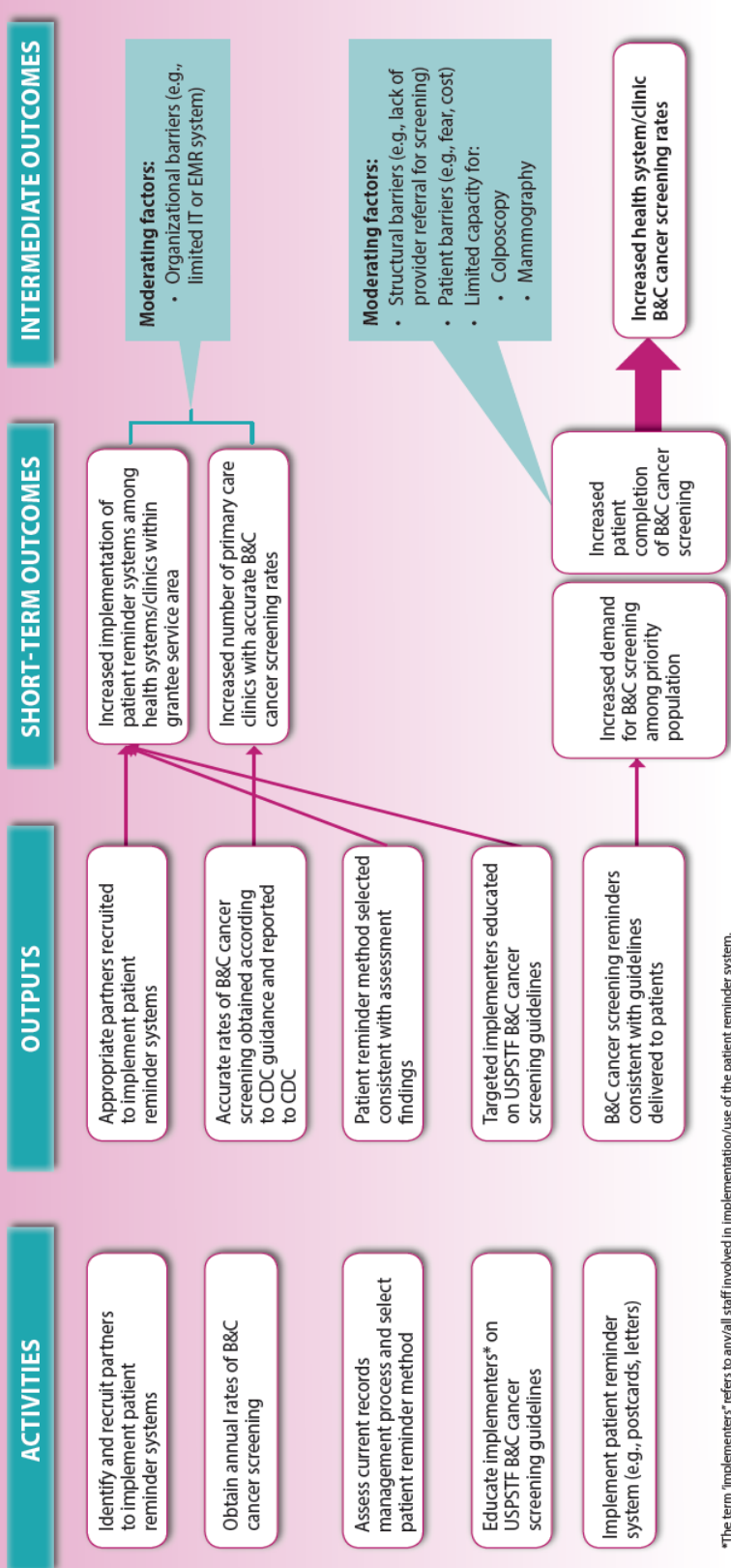
Centers for Disease Control and Prevention
 National Center for Chronic Disease Prevention and Health Promotion

C230462-8



Patient Reminders for the NBCCEDP – Logic Model

EVIDENCE-BASED STRATEGY



Monitoring and Evaluation by Grantee

Definitions/Abbreviations

USPSTF = United States Preventive Services Task Force
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 Research-tested messages and designs for health communications materials

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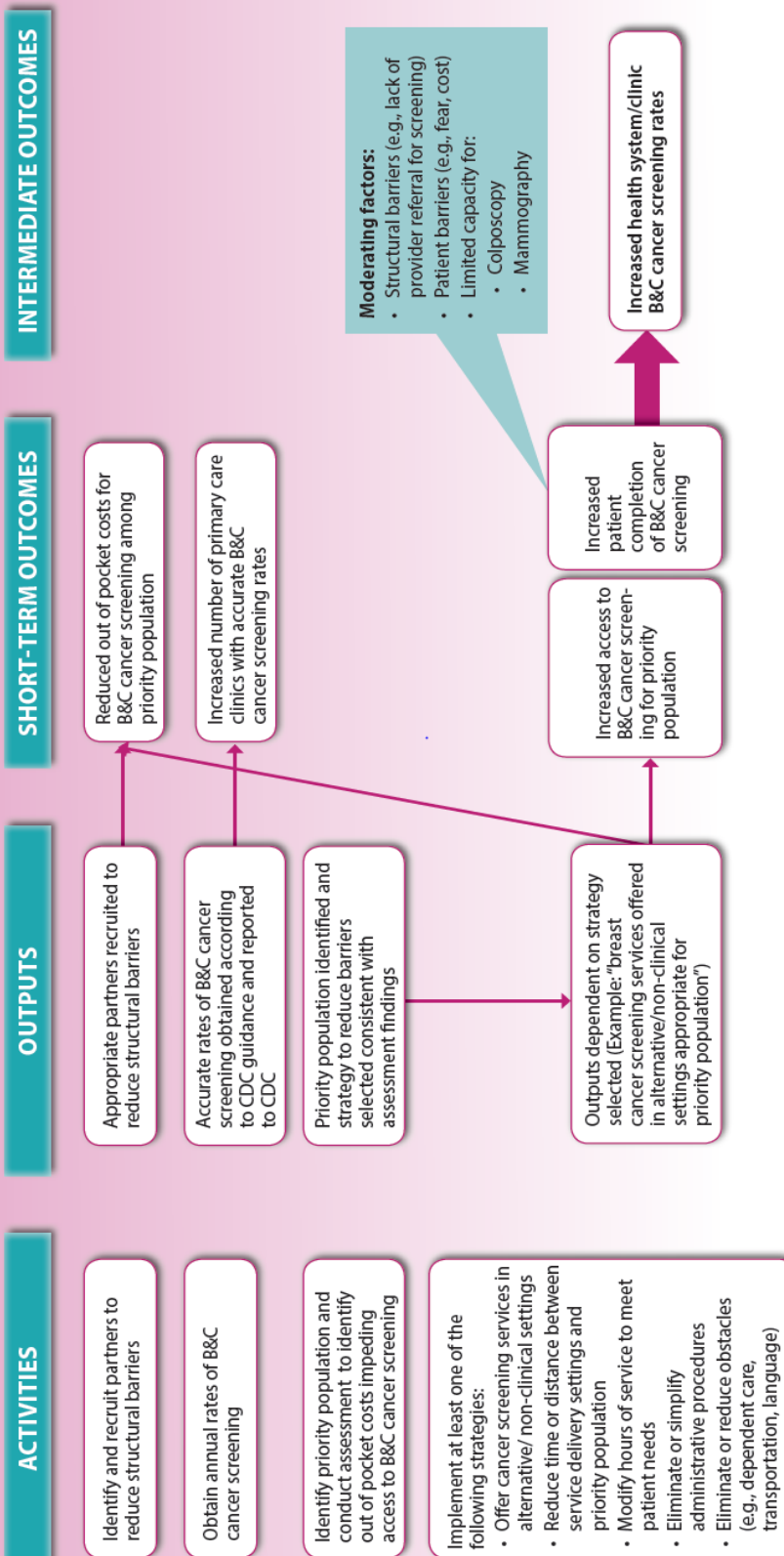
Centers for Disease Control and Prevention
 National Center for Chronic Disease Prevention and Health Promotion

C33862a



Reducing Structural Barriers for the NBCCEDP – Logic Model

EVIDENCE-BASED STRATEGY



Monitoring and Evaluation by Grantee

Definitions/Abbreviations

USPSTF = United States Preventive Services Task Force
 MHO = "Make It Your Own" www.myooworks.org
 Research-tested messages and designs for health communications materials

EMR = Electronic Medical Records
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August 2017



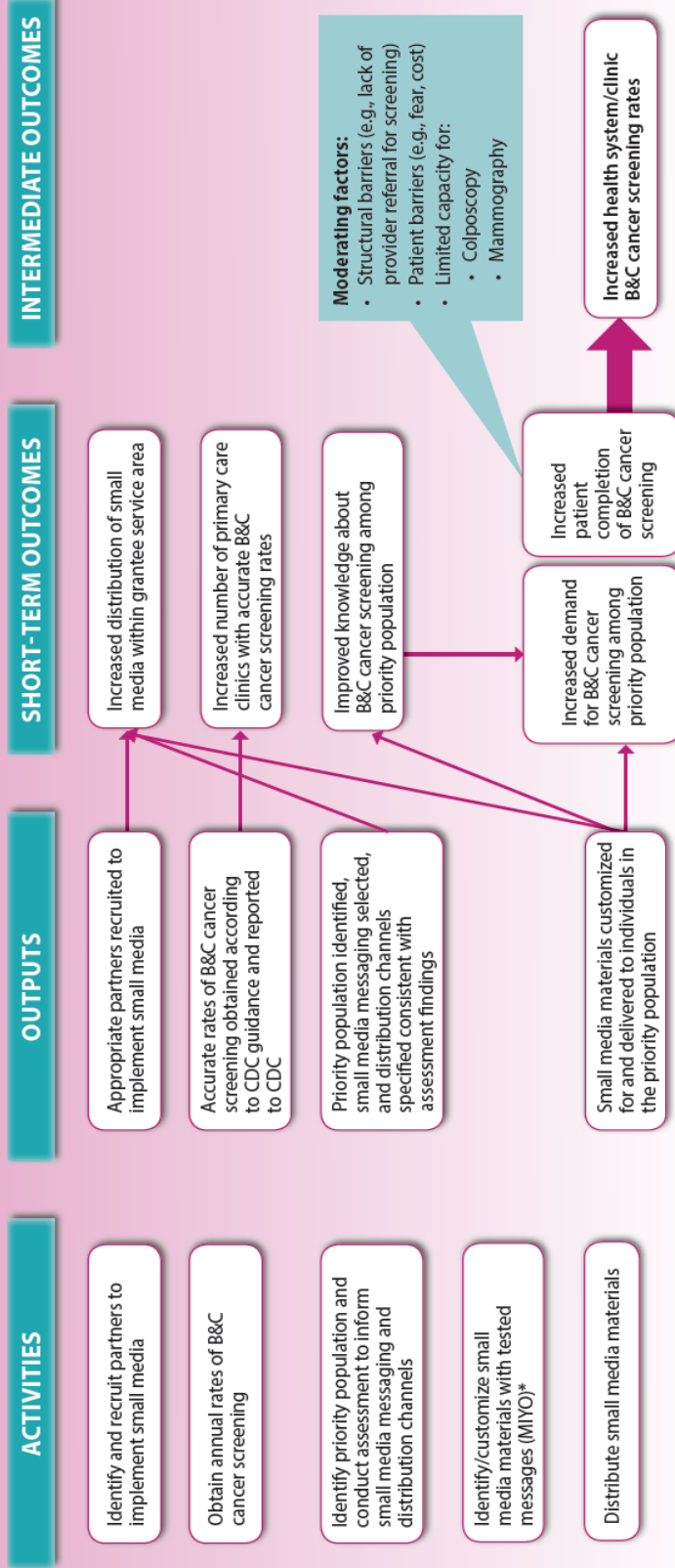
Centers for Disease Control and Prevention
 National Center for Chronic Disease Prevention and Health Promotion

C329462-8



Small Media for the NBCCEDP– Logic Model

EVIDENCE-BASED STRATEGY



*CDC recommends use of scientifically tested messages (MIYO) or, if grantee is developing original materials, that adequate message testing be conducted.

Monitoring and Evaluation by Grantee

Definitions/Abbreviations

USPSTF = United States Preventive Services Task Force
 MIYO = "Make It Your Own" www.miyoworks.org
 Research-tested messages and designs for health communications materials

EMR = Electronic Medical Records
 PN = Patient Navigation
 CHWs = Community Health Workers

August 2017



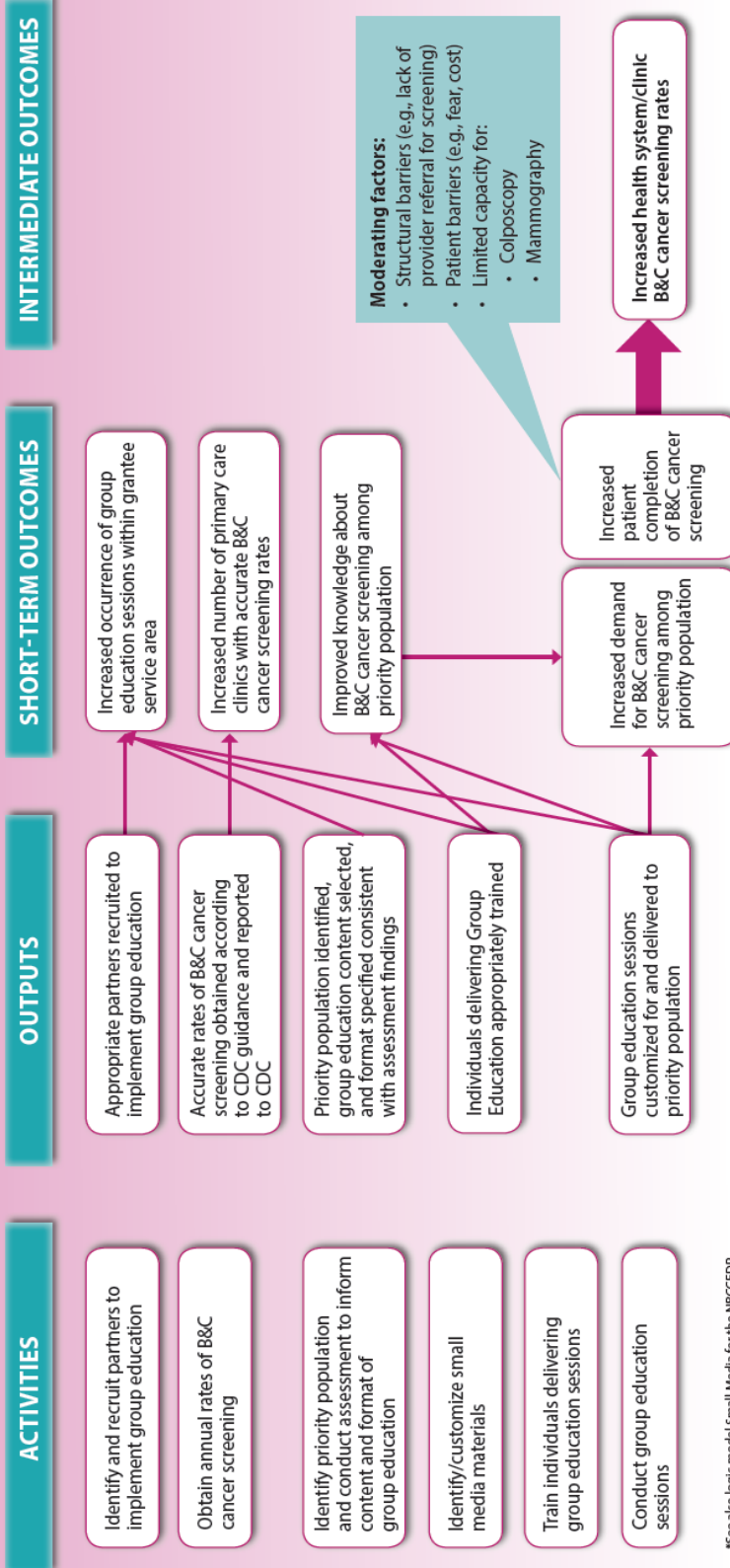
Centers for Disease Control and Prevention
 National Center for Chronic Disease Prevention and Health Promotion

C25BAC3.8



Group Education for the NBCCEDP– Logic Model

EVIDENCE-BASED STRATEGY



*See also logic model Small Media for the NBCCEDP.

Monitoring and Evaluation by Grantee

Definitions/Abbreviations

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 MHO = "Make It Your Own" www.myooworks.org
 Research-tested messages and designs for health communications materials

EMR = Electronic Medical Records
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August 2017



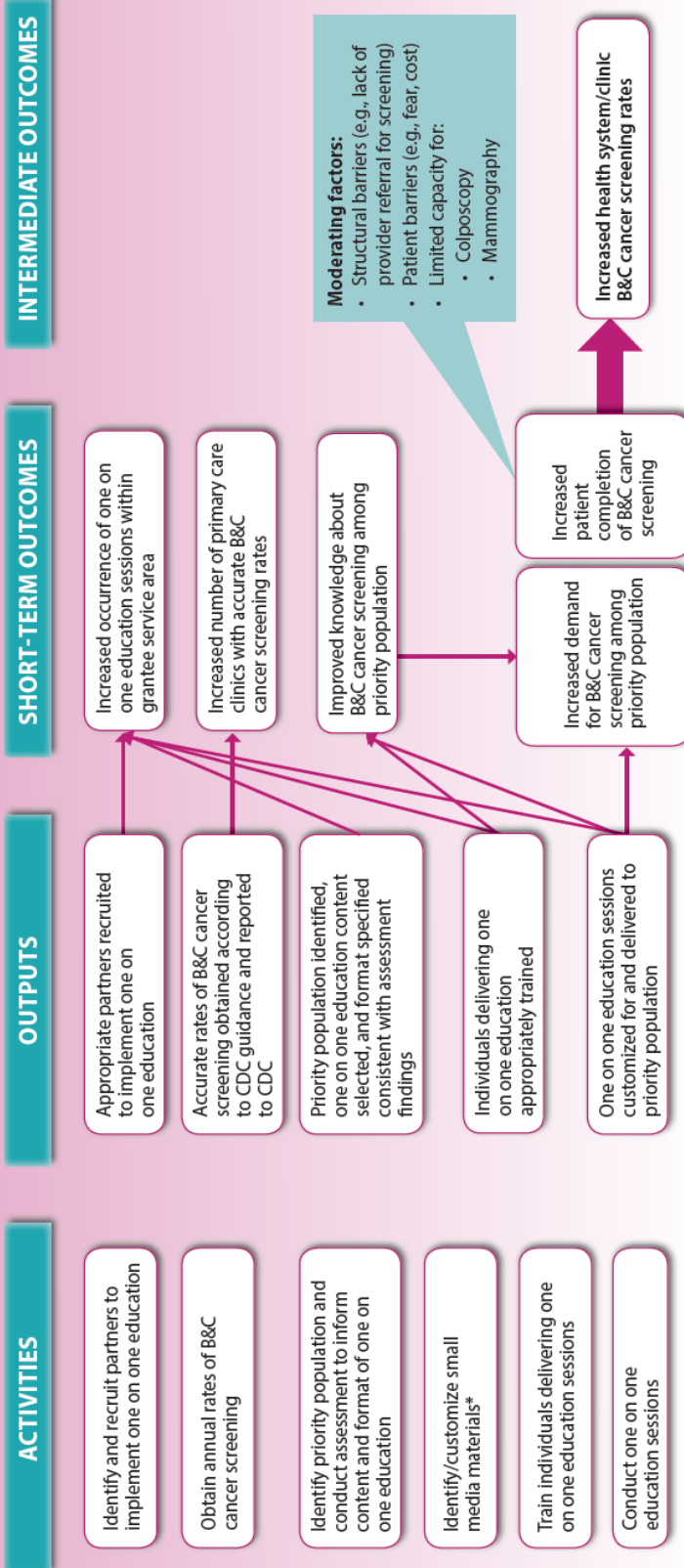
Centers for Disease Control and Prevention
 National Center for Chronic Disease Prevention and Health Promotion

CC30002-8



One on One Education for the NBCCEDP– Logic Model

EVIDENCE-BASED STRATEGY



*See also logic model Small Media for the NBCCEDP.

Monitoring and Evaluation by Grantee

Definitions/Abbreviations

USPSTF = United States Preventive Services Task Force
 MIYO = "Make It Your Own" www.miyoworks.org
 Research-tested messages and designs for health communications materials

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August 2017



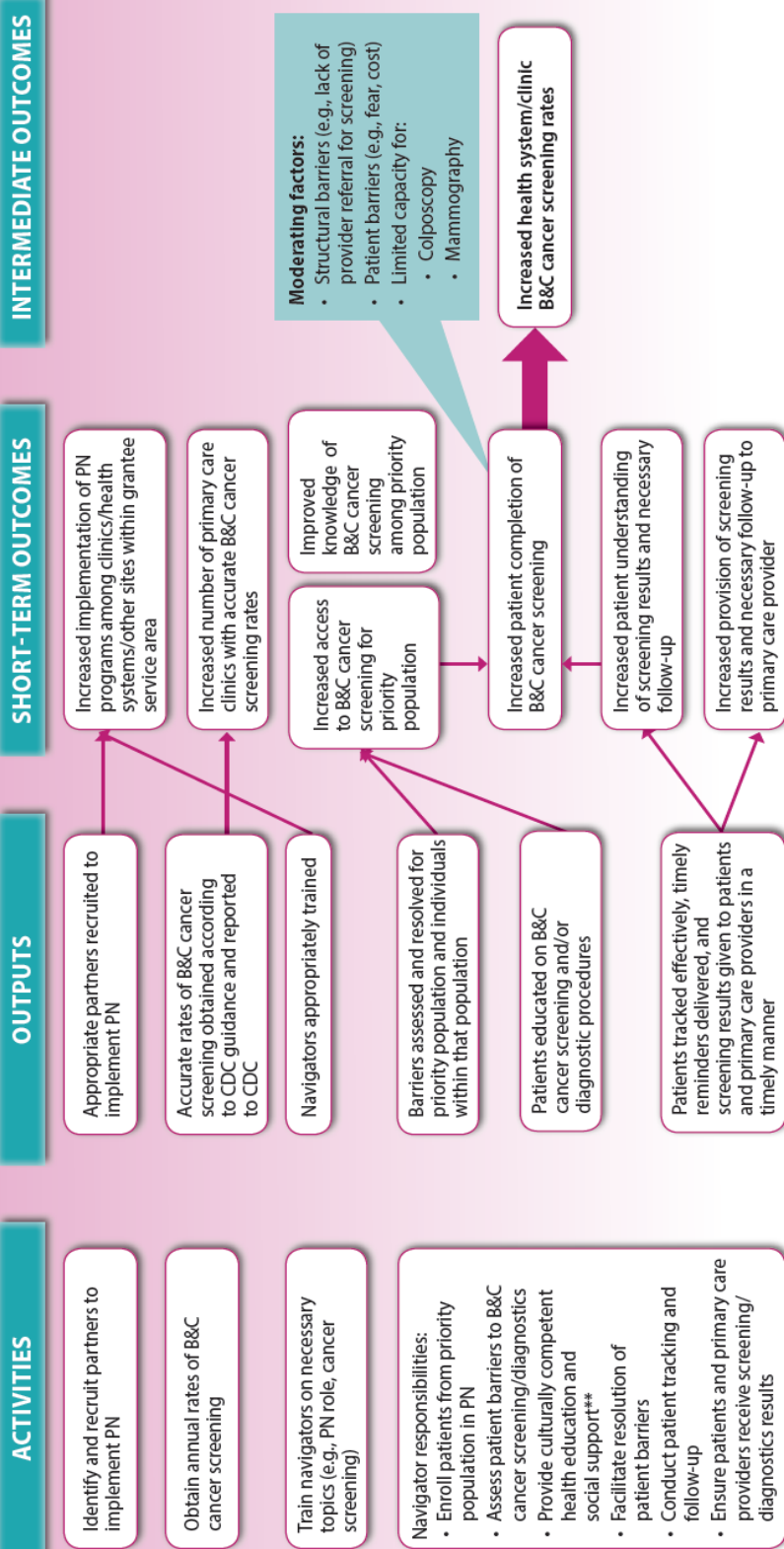
Centers for Disease Control and Prevention
 National Center for Chronic Disease Prevention and Health Promotion

C25962-8



Patient Navigation (PN) for the NBCCEDP – Logic Model

PROGRAM SUPPORTED ACTIVITY



**See also logic models for One on One and Group Education for the NBCCEDP

Monitoring and Evaluation by Grantee

Definitions/Abbreviations

USPSTF = United States Preventive Services Task Force
 MHO = "Make It Your Own" www.mhoyoworks.org
 Research-tested messages and designs for health communications materials

EMR = Electronic Medical Records
 PN = Patient Navigation
 CHWs = Community Health Workers

August 2017



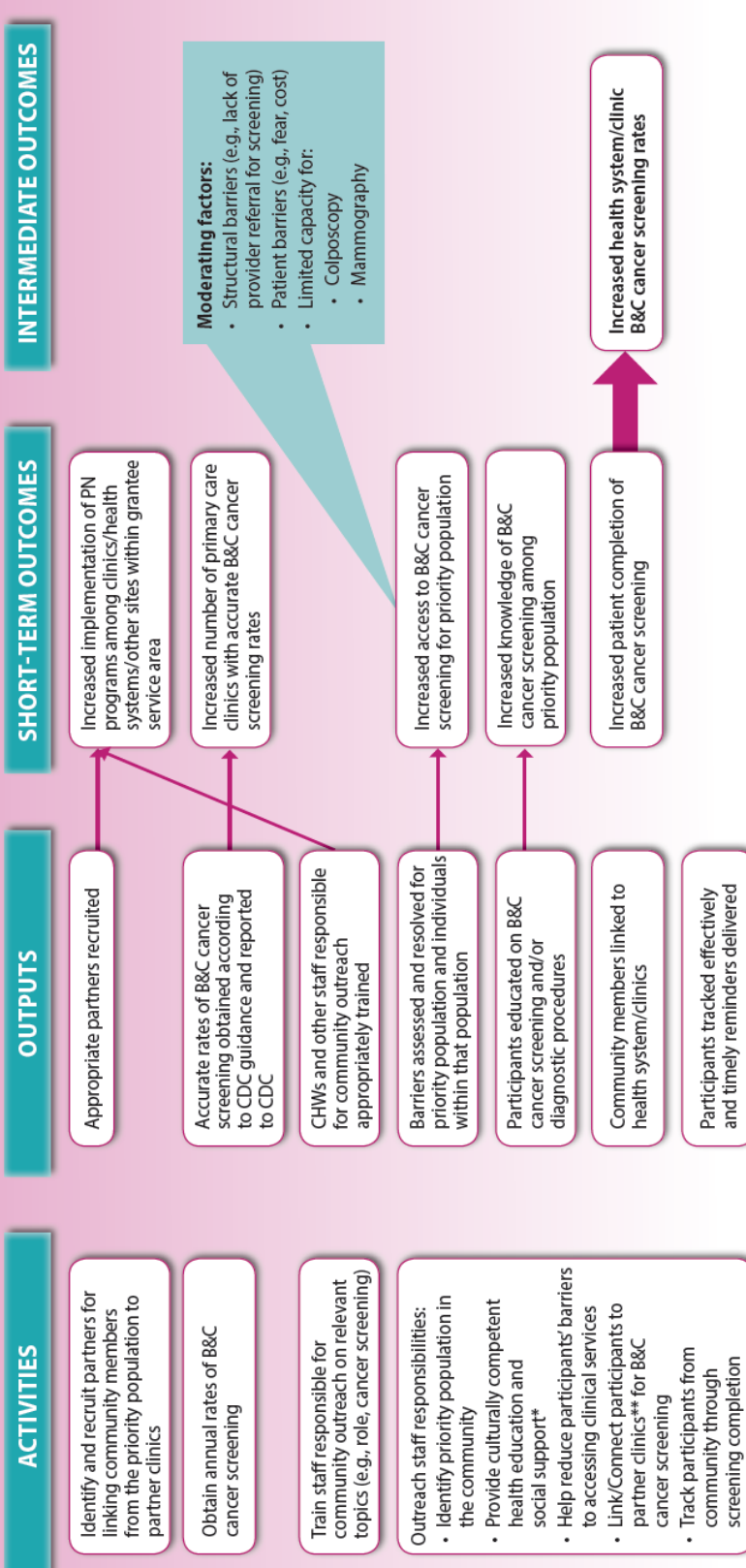
Centers for Disease Control and Prevention
 National Center for Chronic Disease Prevention and Health Promotion

C230462-8



Community Outreach for the NBCCEDP – Logic Model

PROGRAM SUPPORTED ACTIVITY



*See also logic models for One on One and Group Education for the NBCCEDP

**When possible, link patients to clinics where BCCEDP programs are in place

Monitoring and Evaluation by Grantee

Definitions/Abbreviations

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 Research-tested messages and designs for health communications materials

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 CHWs = Community Health Workers

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 National Center for Chronic Disease Prevention and Health Promotion

C35862-a



Appendix D: DP17-1701 MOU and MOA Requirements

The purpose of each Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA) is to clearly define the mutual goals and the working relationship between partners. Further, it outlines the responsibilities of the grantee and each participating health system partner, or other entity, to conduct work directly funded by this funding opportunity announcement. The MOU/MOA must be between the grantee and the partner. A separate, additional agreement or contract is required between the grantee and any intermediaries. The MOU/MOA must be detailed, specific, and binding and outline who, what, and when.

The MOU/MOA must include:

- 1) Names of parties/agencies/organizations entering the agreement.
- 2) An effective **date range** that spans the length of the proposed project.
- 3) Commitment of the participating partner to work with the grantee and other collaborative partners to address program requirements and implement project activities. **Must delineate specific roles of partner in achieving the goals of the FOA.**
- 4) Commitment to collaboratively
 - **assess the needs and existing capacity** to achieve goals
 - **select and implement activities** described in the FOA
 - **monitor implementation progress**
 - **evaluate outcomes and success** of the partnership
 - **participate in data reporting and evaluation activities** required by CDC
- 5) Commitment of the grantee to work with the partner and other collaborative partners to address project requirements, including the **designation of point(s) of contact** within the grantee organization and the partner **with authority to make program-related decisions** and dedicated to the implementation of the proposed applicant activities.
- 6) While this is not a contract, if an exchange of funds is involved, the budget and justification should be outlined here along with deliverables/services to be provided. (Do not insert the contract.)
- 7) Counter-signatures for both parties by authorized representatives

The MOU outline might include Purpose, Background and Objectives, Terms of the Memorandum including dates, Responsibilities of the (grantee), Responsibilities of the (partner health system), Funding, Authorized Representatives, Amending/Terminating the Agreement.



Appendix E: NBCCEDP MDE and Clinical Quality Indicators

Minimum Data Elements

CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) grantees establish provider networks to deliver breast and cervical cancer screening services to eligible women. Grantees maintain a data system to monitor and track clinical care to ensure high-quality screening and diagnostic services and initiation of treatment for women diagnosed with cancer.

Twice a year, grantees report to CDC a standardized record on every screening encounter provided through the program. The data are called the minimum data elements (MDEs) and represent the subset of data required by CDC to monitor screening performance.

Each MDE record describes a screening cycle that starts with a screening test and tracks the women through any immediate follow-up of abnormal findings needed to complete diagnostic evaluation and initiate treatment. A unique patient identification number facilitates tracking screening services to a woman over time.

A description of the MDE record is attached. An updated MDE version is planned for DP17-1701 to streamline the data collection and include records for individuals receiving navigation services through the program.

Clinical Quality Indicators

Clinical quality indicators are used to measure clinical performance by assessing reach to priority populations and timeliness of follow-up services and treatment referral. The measures for these indicators are derived from the minimal data elements submitted by grantees.

A description of the clinical indicators is attached. An updated set of indicators is planned for DP17-1701 to correspond with the MDE collection and program guidelines.



NBCCEDP Minimum Data Elements (MDEs)

Version 6, effective January 1, 2009

All Patient Section

Category	Data Item Name	Purpose
Enrollment Location	State, Territorial, or Tribal Program of Screening	Grantee FIPS or Tribal Program code
	County of Screening	FIPS code for the county of the primary B&C provider
	Enrollment Site	Point of enrollment into the program
Patient/Record Id	Patient ID Number	Patient's identification number
	Record Identifier	Uniquely identify one record among many for a woman
Patient Demographics	County of Residence	FIPS code for the county of residence
	State or Territory of Residence	FIPS code for the state or territory of residence
	Zip Code of Residence	Zip code of residence
	Date of Birth	Date of birth
	Race 1 - 5	Up to 5 self-identified race groups
	Hispanic or Latino Origin	Hispanic or Latino origin
Clinical Breast Exam screening information	Breast Symptoms	Breast symptoms reported by the woman
	Clinical Breast Exam (CBE)	Provider's assessment of the Clinical Breast Exam
	Date of Clinical Breast Exam (CBE)	Date of CBE
	Clinical Breast Exam Paid by NBCCEDP Funds	If CBE was paid for with NBCCEDP funds
Cervical screening information	Previous Pap Test	If a woman has had a previous Pap test
	Date of Previous Pap Test	Date of previous Pap test
	Indication for Pap Test	Reason for Pap test or cervical visit
	Cervical Diagnostic Referral Date	Enrollment date of patient referred to program for diagnostic evaluation after abnormal Pap performed outside the program
	Bethesda System Used	Whether the Pap test results for a woman were reported using the 1991 or 2001 Bethesda System Categories
	Specimen Adequacy of Screening Pap Test	Specimen adequacy as noted under the Bethesda System
	Specimen Type for Pap Test	How specimen was collected (LBT / conventional)
	Results of Screening Pap Test (Bethesda 1991)	Results of screening Pap test using the 1991 Bethesda System
	Results of Screening Pap Test (Bethesda 2001)	Results of screening Pap test using the 2001 Bethesda System
	Other Screening Pap Test Results	Specify other screening Pap test results
	Date of Screening Pap Test	Date of screening Pap test
	Screening Pap Test Paid by NBCCEDP Funds	If Pap test, laboratory services, or pelvic exam were paid by NBCCEDP funds
	Result of HPV Test	HPV test result
	Date of HPV Test	HPV test date
	HPV Test Paid by NBCCEDP Funds	If HPV test was paid by NBCCEDP funds



Category	Data Item Name	Purpose
	Diagnostic Work-Up Planned for Cervical Dysplasia or Cancer	Clinical recommendation for immediate diagnostic work-up
Initial Mammogram Information	Previous Mammogram	If a woman has had a previous mammogram
	Date of Previous Mammogram	Date of previous mammogram
	Indication for Initial Mammogram	Reason for mammogram
	Breast Diagnostic Referral Date	Enrollment date of patient referred to program for diagnostic evaluation after abnormal breast screen performed outside the program
	Mammography Test Results	Results of mammography using the American College of Radiology lexicon (V6 added Assessment Incomplete- need Film Comparison)
	Date of Mammogram	Date of mammography
	Mammogram Paid by NBCCEDP Funds	If mammogram was paid for by NBCCEDP funds
	Diagnostic Work-Up Planned for Breast Cancer	Clinical recommendation for immediate diagnostic work-up
Internal Use	MDE Version Number	MDE version used for submitting data



Additional Cervical Procedures Section

Category	Data Item Name	Purpose
Cervical Diagnostic Procedures	Colposcopy without Biopsy	If colposcopy without biopsy was performed
	Colposcopy-Directed Biopsy	If a colposcopy-directed biopsy was performed (v6 specifies Colpo w/biopsy and/or ECC)
	Loop Electrosurgical Excision Procedure (LEEP)	If LEEP was performed
	Cold Knife Cone	If KKC was performed
	Endocervical Curettage alone (ECC)	If ECC was performed
	Other Procedures Performed	If other diagnostic procedures were performed
	Description of Other Procedures Performed	Specify other diagnostic procedures performed
	Cervical Diagnostic Procedures Paid by NBCCEDP Funds	If one or more diagnostic procedures were paid with NBCCEDP funds
Cervical Diagnosis Information	Status of Final Diagnosis	Status of final cervical diagnosis
	Final Diagnosis	Final cervical diagnosis
	Final Diagnosis—Other	Specify final cervical diagnosis of “other”
	Date of Final Diagnosis	Date of final cervical diagnosis
	Stage at Diagnosis	Stage at diagnosis for women with invasive cervical cancer (v5 legacy)
Cervical Cancer Treatment	Status of Treatment	Status of treatment for precancerous lesions and cervical cancer
	Date of Treatment Status	Date of treatment status

Additional Breast Procedures Section

Category	Data Item Name	Purpose
Additional Breast Imaging Procedures	Additional Mammographic Views	If additional mammographic views were performed
	Ultrasound	If an ultrasound was performed
	Film Comparison to evaluate Assessment Incomplete	If a film comparison was performed to evaluate an assessment incomplete mammogram result
	Final Imaging Outcome	Final imaging outcome following assessment incomplete mammogram result
	Date of Final Imaging Outcome	Date of final imaging outcome
Breast Diagnostic Procedures	Repeat Breast Exam/Surgical Consultation	If a repeat breast exam and/or surgical consultation was performed
	Biopsy/Lumpectomy	If a biopsy or lumpectomy was performed
	Fine-needle/Cyst Aspiration	If a fine-needle or cysts aspiration was performed
	Other Procedures Performed	If other diagnostic procedures were performed
	Description of Other Procedures Performed	Specify other diagnostic procedures performed
	Breast Diagnostic Procedures Paid by NBCCEDP Funds	If one or more diagnostic procedures were paid for with NBCCEDP funds
Breast Diagnosis Information	Status of Final Diagnosis	Status of final diagnosis
	Final Diagnosis	Final breast cancer diagnosis
	Date of Final Diagnosis/imaging	Date of final diagnosis
	Stage at Diagnosis	Stage at diagnosis for women with invasive breast cancer (v5 legacy)
	Tumor Size	Tumor size for women with invasive breast cancer (v5 legacy)



Category	Data Item Name	Purpose
Breast Cancer	Status of Treatment	Status of initiation of treatment for breast cancer
Treatment	Date of Treatment Status	Date of treatment status

Registry Acquired Data Items, NBCCEDP Cancer Records Only

Category	Item Name	Purpose
Registry data acquired through data linkages on breast and cervical cancers diagnosed through the NBCCEDP	Registry Linkage Status	If record linkage attempted or matched
	Registry Date of Diagnosis	Confirm NBCCEDP diagnostic outcomes, facilitate record matching, and provide standardized cancer stage data
	Registry Histologic Type	
	Registry Behavior	
	Registry Summary Stage	
	Registry Collaborative Stage Derived AJCC Stage Group	
	Registry Collaborative Stage Tumor Size	
	Registry Collaborative Stage Extension	
	Registry Collaborative Stage Lymph Nodes	
	Registry Collaborative Stage Mets at Diagnosis	
	Registry Primary Site	



NBCCEDP Clinical Quality Indicators

Measure Type	Performance Measure	Target
Screening the Priority Population	Priority population for cervical cancer screening: Percentage of initial program Pap tests provided to women never screened for cervical cancer.	$\geq 20\%$
	Priority population for breast cancer screening: Percentage of screening mammograms provided to women ages 50 and older.	$\geq 75\%$
Complete and Timely Diagnostic Follow-up of Abnormal Screening Results	Complete Cervical Diagnostic Follow-up: Percentage of abnormal cervical screens with diagnostic evaluation completed.	$\geq 90\%$
	Timely Cervical Diagnostic Follow-up: Percentage of abnormal cervical screens with time from screening to final diagnosis more than 90 days.	$\leq 25\%$
	Complete Breast Diagnostic Follow-up: Percentage of abnormal breast screens with diagnostic evaluation completed.	$\geq 90\%$
	Timely Breast Diagnostic Follow-up: Percentage of abnormal breast screens with time from screening test result to final diagnosis more than 60 days.	$\leq 25\%$
Complete and Timely Initiation of Treatment for Cancers Diagnosed	Treatment Started for Cervical Cancer: Percentage of women diagnosed with invasive cervical cancer or premalignant high-grade lesions who have initiated treatment.	$\geq 90\%$
	Timely Treatment for Premalignant Cervical Lesions: Percentage of women diagnosed with premalignant high-grade cervical lesions with time from date of diagnosis to treatment started more than 90 days.	$\leq 20\%$
	Timely Treatment for Invasive Cervical Cancer: Percentage of women diagnosed with invasive cervical cancer with time from date of diagnosis to treatment started more than 60 days.	$\leq 20\%$
	Treatment Started for Breast Cancer: Percentage of women diagnosed with breast cancer initiating treatment.	$\geq 90\%$
	Timely Treatment for Breast Cancer: Percentage of women diagnosed with breast cancer with time from date of diagnosis to treatment started more than 60 days.	$\leq 20\%$



Appendix F: Abbreviated Clinic Data Collection Dictionaries

NBCCEDP Clinic-level Data for BREAST CANCER SCREENING AND RELATED ACTIVITIES (Abbreviated View)

Category	Name	Description or Purpose
Section 1: Record Identification	Grantee code	CDC-assigned grantee ID
	Baseline assessment date	Date baseline assessment was completed; represents the starting point for tracking clinic breast cancer screening implementation activities and screening rates
Section 2: Partner Health System Characteristics	Health system name	Name of the health system the clinic (intervention site) operates within
	Health system ID	Grantee-assigned health system ID.
	Total # of primary care clinics in health system	Health system size and potential reach
	Health System Type	Health system organization type
	Other health system type	Specify type, if "other"
	Type of agreement in place with the health system	Formal agreement between grantee and health system; represents the relationship
	Date of formal agreement	Date the formal agreement was finalized
	Health Center Controlled Network name	CHC HCCN partner, if any; represents capacity
Section 3: Clinic Characteristics	Clinic name	Name of the primary care clinic/site (intervention site)
	Clinic ID	Grantee-assigned clinic ID
	Clinic street address	Clinic location; geographic assessment of reach
	Clinic city	
	Clinic state	
	Clinic zip	
	Clinic type	Clinic organizational type
	# of primary care providers at clinic	Clinic provider volume and potential reach
	Name of primary EHR vendor at clinic	EHR vendors used
	Other EHR, please specify	Specify EHR, if "other"
	Other HIT tools used for data analytics and reporting	Other HIT tools (such as EHR overlay) used to monitor or improve screening
	Patient Centered Medical Home recognition	Clinic recognized, certified, or accredited as a PCMH; represents capacity
	Newly opened clinic	Unique reporting criteria
Section 4: Clinic Patient Population Characteristics for Breast Cancer	Total # of clinic patients, age 50-74, women	Patients aged 50-74 who have had at least one medical visit to the clinic in the last complete calendar year (Jan-Dec); represents reach
	% of patients, age 50-74, women	Clinic population, by gender
	% of patients, age 50-74, uninsured, women	Clinic population, by insurance status
	% of patients, age 50-74, Hispanic, women	Clinic population, by ethnicity
	% of patients, age 50-74, White, women	Clinic population, by race
	% of patients, age 50-74, Black or African American women	



Category	Name	Description or Purpose
	% of patients, age 50-74, Asian, women	
	% of patients, age 50-74, NatHawaiian/OthPaclSI, women	
	% of patients, age 50-74, Amer Indian/AK Native, women	
	% of patients, age 50-74, More than one race, women	
Section 5: Report Period for Longitudinal Data Items	Report period	NBCCEDP reporting period for longitudinal data (baseline or annual PY1-PY5)
	Implementation status	Indicates if NBCCEDP resources were used to support implementation of at least 1 or more EBIs to increase breast cancer screening. Use to assess duration of implementation
	Implementation start date	Date, when EBI implementation activities began
	Activity partnership status	Indicates if breast cancer activities with this clinic were terminated with no implementation activities conducted this PY or planned through end of FOA. Use for data entry and reporting controls.
	Reason for termination	Reason, if breast cancer activities with this clinic were terminated.
	Termination date	Date, if clinic breast cancer activities were terminated.
Section 6: Chart Review (CR) Screening Rate Data for Breast Cancer <i>Screening rate data may be reported using chart review, EHR or both</i>	Breast cancer screening rate (%)	System generated; NBCCEDP outcome measure. Refer to <i>CDC Guidance for Measuring Breast, Cervical, and Colorectal Cancer Screening Rates in Health System Clinics</i> .
	CR Denominator to calculate screening rate	
	CR Numerator to calculate screening rate	
	If screening rate unavailable, date the rate will be available	Tracking mechanism to ensure the screening rate is acquired
	Measure used	Identify specific measure used to calculate screening rate numerator and denominator
	Start date of 12-month reporting period	Identify the timeframe represented and ensure a consistent 12-month reporting period is used over time for NBCCEDP reporting
	End date of 12-month reporting period	
	% of charts reviewed to calculate screening rate	Assess scale of the chart review and consistency with CDC guidance.
	Sampling method	Assess appropriate methodology for conducting CR and consistency with CDC guidance
Section 7: Electronic Health Record (EHR) Screening Rate	EHR Screening rate (%)	System generated; NBCCEDP outcome measure. Refer to <i>CDC Guidance for Measuring Breast, Cervical, and Colorectal Cancer Screening Rates in Health System Clinics</i> .
	EHR Denominator to calculate screening rate	
	EHR Numerator to calculate screening rate	



Category	Name	Description or Purpose
Data for Breast Cancer <i>Screening rate data may be reported using chart review, EHR or both</i>	If screening rate unavailable, date the rate will be available	Tracking mechanism to ensure the screening rate is acquired
	Measure used	Identify specific measure used to calculate screening rate numerator and denominator.
	Start date of 12-month reporting period	Identify the timeframe represented and ensure a consistent 12-month reporting period is used over time for NBCCEDP reporting
	End date of 12-month reporting period	
	EHR rate reporting source	Assess reporting sources; intended to inform data quality or consistency assessment
	How confident are you in the accuracy of the EHR-calculated screening rate?	Assess quality of the rate reported; intended to inform data interpretation
	Screening rate problem	Recognize rate problems to inform data interpretation and intervention activities
	Specify screening rate problem	Assess type and impact of unresolved problems with rate or underlying data
	Screening rate target	Encourage realistic, actionable target setting
Section 8: Monitoring and Quality Improvement for Breast Cancer Screening	Screening policy	Does clinic have a written breast cancer screening policy or protocol in use? Potential clinic capacity or program outcome measure.
	Frequency of monitoring screening rate	Implementation monitoring indicator
	Frequency of implementation support to clinic	Implementation monitoring indicator
	Validated screening rate	Data quality monitoring for breast cancer screening
	Champion at clinic or health system	Potential impact on program outcomes for breast cancer screening
	BCCEDP clinical services	BCCEDP-funded clinical services provided at this clinic
Section 9: Evidence-based Interventions (EBIs) <i>Grantees are NOT EXPECTED to participate in all EBIs but must respond to all required data items.</i>	Collect data below for each EBI (patient reminder system, provider reminder system, provider assessment and feedback, reducing structural barriers, small media, patient education, and reducing out of pocket costs).	
	<Activity> in place and operational at baseline	<Activity> Identify pre-existing interventions before NBCCEDP DP17-1701 implementation, regardless of the quality, reach, or current level of functionality.
	Were NBCCEDP resources used toward this <Activity> during this PY? (y/n)	Identify if NBCCEDP grantee resources (e.g. funds, staff time, materials, contracts, etc.) were used during this year to contribute to planning, developing or implementing this activity
	<Activity> in place and operational at PY end	Implementation stage of this activity at the end of the PY
	<Activity> planning activities conducted this PY	Indicates planning conducted this year for an intervention not in place
	<Activity> sustainability	Indicator of sustained intervention and resources
Section 10: Professional Development and Provider Education	Professional development/provider education in place and operational at baseline	Professional development and provider education Identify pre-existing interventions before NBCCEDP DP17-1701 implementation, regardless of the quality, reach, or current level of functionality.
	Were NBCCEDP resources used toward professional	Identify if NBCCEDP grantee resources (e.g. funds, staff time, materials, contracts, etc.) were used during this year to



Category	Name	Description or Purpose
	development and provider education during this PY? (y/n)	contribute to planning, developing or implementing this activity
	Professional development and provider education in place and operational at PY end	Implementation stage of this activity at the end of the PY
Section 11: Community outreach, education, and support	<Activity> in place and operational at baseline	<Community outreach, education, and support> Identify pre-existing interventions before NBCCEDP DP17-1701 implementation, regardless of the quality, reach, or current level of functionality.
	Were NBCCEDP resources used toward this <Activity> during this PY? y/n	Identify if NBCCEDP grantee resources (e.g. funds, staff time, materials, contracts, etc.) were used during this year to contribute to planning, developing or implementing this activity
	<Activity> in place and operational at PY end	Implementation stage of this activity at the end of the PY
	<Activity> planning activities conducted this PY	Indicates planning conducted this year for an intervention not in place
	<Activity> sustainability	Indicator of sustained intervention and resources
	If CHWs used, # of FTE CHWs	
	Other community-clinical linkage activities	Assess types of community-clinical linkage activities conducted at clinics
Section 12: Patient Navigation for screening, diagnostics, and/or treatment initiation	<Activity> in place and operational at baseline	<Patient navigation for screening, diagnostics, and/or treatment initiation> Identify pre-existing interventions before NBCCEDP DP17-1701 implementation, regardless of the quality, reach, or current level of functionality.
	Were NBCCEDP resources used toward this <Activity> during this PY? y/n	Identify if NBCCEDP grantee resources (e.g. funds, staff time, materials, contracts, etc.) were used during this year to contribute to planning, developing or implementing this activity
	<Activity> in place and operational at PY end	Implementation stage of this activity at the end of the PY
	<Activity> planning activities conducted this PY	Indicates planning conducted this year for an intervention not in place
	<Activity> sustainability	Indicator of sustained intervention and resources
	If PN in place, # of FTEs delivering patient navigation	
	If PN in place, # of clients navigated	
Section 13: Other Breast Cancer-related Strategies	Activities to improve HIT use for breast cancer screening	HIT activities at baseline
	Other breast cancer-related strategies currently in place	Other activities in place at baseline
	Other <Activity>	<Other breast cancer activity or strategy>
	Were NBCCEDP resources used toward this <activity> during this PY? (y/n)	



NBCCEDP Clinic-level Data for CERVICAL CANCER SCREENING AND RELATED ACTIVITIES (Abbreviated View)

Category	Name	Description or Purpose
Section 1:	Grantee code	CDC-assigned grantee ID
	Baseline assessment date	Date baseline assessment was completed; represents the starting point for tracking clinic cervical cancer screening implementation activities and screening rates
Record Identification		
Section 2:	Health system name	Name of the health system the clinic (intervention site) operates within
	Health system ID	Grantee-assigned health system ID.
Partner Health System Characteristics	Total # of primary care clinics in health system	Health system size and potential reach
	Health system type	Health system organization type
	Other health system type	Specify type, if "other"
	Type of agreement in place with the health system	Formal agreement between grantee and health system; represents the relationship
	Date of formal agreement	Date the formal agreement was finalized
	Health Center Controlled Network name	CHC HCCN partner, if any; represents capacity
Section 3:	Clinic name	Name of the primary care clinic/site (intervention site)
	Clinic ID	Grantee-assigned clinic ID
	Clinic street address	Clinic location; geographic assessment of reach
	Clinic city	
	Clinic state	
	Clinic zip	
	Clinic type	Clinic organizational type
	# of primary care providers at clinic	Clinic provider volume and potential reach
	Name of primary EHR vendor at clinic	EHR vendors used
	Other EHR, please specify	Specify EHR, if 'other'
	Other HIT tools used for data analytics and reporting	Other HIT tools (such as EHR overlay) used to monitor or improve screening
	Patient Centered Medical Home recognition	Clinic recognized, certified, or accredited as a PCMH; represents capacity
	Newly opened clinic	Unique reporting criteria
Section 4:	Total # of clinic patients, age 21-64, women	Patients aged 21-64 who have had at least one medical visit to the clinic in the last complete calendar year (Jan-Dec); represents reach
	% of patients, age 21-64, women	Clinic population, by gender
	% of patients, age 21-64, uninsured, women	Clinic population, by insurance status
	% of patients, age 21-64, Hispanic, women	Clinic population, by ethnicity
	% of patients, age 21-64, White, women	Clinic population, by race
	% of patients, age 21-64, Black or African Amer, women	
	% of patients, age 21-64, Asian, women	



Category	Name	Description or Purpose
	% of patients, age 21-64, NatHawaiian/OthPaclSI, women	
	% of patients, age 21-64, Amer Indian/AK Native, women	
	% of patients, age 21-64, more than one race, women	
Section 5: Report Period for Longitudinal Data Items	Report period	NBCCEDP reporting period for longitudinal data (baseline or annual PY1-PY5)
	Implementation status	Indicates if NBCCEDP resources were used to support implementation of at least 1 or more EBIs to increase cervical cancer screening. Use to assess duration of implementation
	Implementation start date	Date, when EBI implementation activities began
	Activity partnership status	Indicates if cervical cancer activities with this clinic were terminated with no implementation activities conducted this PY or planned through end of FOA. Use for data entry and reporting controls.
	Reason for termination	Reason, if cervical cancer activities with this clinic were terminated.
	Termination date	Date, if clinic cervical cancer activities were terminated.
Section 6: Chart Review (CR) Screening Rate Data for Cervical Cancer <i>Screening rate data may be reported using chart review, EHR or both</i>	Cervical cancer screening rate (%)	System generated; NBCCEDP outcome measure. Refer to <i>CDC Guidance for Measuring Breast, Cervical, and Colorectal Cancer Screening Rates in Health System Clinics</i> .
	CR Denominator to calculate screening rate	
	CR Numerator to calculate screening rate	
	If screening rate unavailable, date the rate will be available	Tracking mechanism to ensure the screening rate is acquired
	Measure used	Identify specific measure used to calculate screening rate numerator and denominator
	Start date of 12-month reporting period	Identify the timeframe represented and ensure a consistent 12-month reporting period is used over time for NBCCEDP reporting
	End date of 12-month reporting period	
	% of charts reviewed to calculate screening rate	Assess scale of the chart review and consistency with CDC guidance.
	Sampling method	Assess appropriate methodology for conducting CR and consistency with CDC guidance
Section 7: Electronic Health Record (EHR) Screening Rate	EHR Screening rate (%)	System generated; NBCCEDP outcome measure. Refer to <i>CDC Guidance for Measuring Breast, Cervical, and Colorectal Cancer Screening Rates in Health System Clinics</i> .
	EHR Denominator to calculate screening rate	
	EHR Numerator to calculate screening rate	



Category	Name	Description or Purpose
Data for Cervical Cancer <i>Screening rate data may be reported using chart review, EHR or both</i>	If screening rate unavailable, date the rate will be available	Tracking mechanism to ensure the screening rate is acquired
	Measure used	Identify specific measure used to calculate screening rate numerator and denominator.
	Start date of 12-month reporting period	Identify the timeframe represented and ensure a consistent 12-month reporting period is used over time for NBCCEDP reporting
	End date of 12-month reporting period	
	EHR rate reporting source	Assess reporting sources; intended to inform data quality or consistency assessment
	How confident are you in the accuracy of the EHR-calculated screening rate?	Assess quality of the rate reported; intended to inform data interpretation
	Screening rate problem	Recognize rate problems to inform data interpretation and intervention activities
	Specify screening rate problem	Assess type and impact of unresolved problems with rate or underlying data
	Screening rate target	Encourage realistic, actionable target setting
Section 8: Monitoring and Quality Improvement for Cervical Cancer Screening	Screening policy	Does clinic have a written cervical cancer screening policy or protocol in use? Potential clinic capacity or program outcome measure.
	Frequency of monitoring screening rate	Implementation monitoring indicator
	Frequency of implementation support to clinic	Implementation monitoring indicator
	Validated screening rate	Data quality monitoring for cervical cancer screening
	Champion at clinic or health system	Potential impact on program outcomes for cervical cancer screening
	BCCEDP clinical services	BCCEDP-funded clinical services provided at this clinic
Section 9: Evidence-based Interventions (EBIs) <i>Grantees are NOT EXPECTED to participate in all EBIs but must respond to all required data items.</i>	Collect data below for each EBI (patient reminder system, provider reminder system, provider assessment and feedback, reducing structural barriers, small media, patient education, and reducing out of pocket costs).	
	<Activity> in place and operational at baseline	<Activity> Identify pre-existing interventions before NBCCEDP DP17-1701 implementation, regardless of the quality, reach, or current level of functionality
	Were NBCCEDP resources used toward this <Activity> during this PY? (y/n)	Identify if NBCCEDP grantee resources (e.g. funds, staff time, materials, contracts, etc.) were used during this year to contribute to planning, developing or implementing this activity
	<Activity> in place and operational at PY end	Implementation stage of this activity at the end of the PY
	<Activity> planning activities conducted this PY	Indicates planning conducted this year for an intervention not in place
	<Activity> sustainability	Indicator of sustained intervention and resources
Section 10: Professional Development and Provider Education	Professional development/provider education in place and operational at baseline	Professional development and provider education Identify pre-existing interventions before NBCCEDP DP17-1701 implementation, regardless of the quality, reach, or current level of functionality
	Were NBCCEDP resources used toward professional	Identify if NBCCEDP grantee resources (e.g. funds, staff time, materials, contracts, etc.) were used during this year to



Category	Name	Description or Purpose
	development and provider education during this PY? (y/n)	contribute to planning, developing or implementing this activity
	Professional development and provider education in place and operational at PY end	Implementation stage of this activity at the end of the PY
Section 11: Community outreach, education, and support	<Activity> in place and operational at baseline	<Community outreach, education, and support> Identify pre-existing interventions before NBCCEDP DP17-1701 implementation, regardless of the quality, reach, or current level of functionality
	Were NBCCEDP resources used toward this <Activity> during this PY? y/n	Identify if NBCCEDP grantee resources (e.g. funds, staff time, materials, contracts, etc.) were used during this year to contribute to planning, developing or implementing this activity
	<Activity> in place and operational at PY end	Implementation stage of this activity at the end of the PY
	<Activity> planning activities conducted this PY	Indicates planning conducted this year for an intervention not in place
	<Activity> sustainability	Indicator of sustained intervention and resources
	If CHWs used, # of FTE CHWs	
	Other community-clinical linkage activities	Assess types of community-clinical linkage activities conducted at clinics
Section 12: Patient navigation for screening, diagnostics, and/or treatment initiation	<Activity> in place and operational at baseline	<Patient navigation for screening, diagnostics, and/or treatment initiation> Identify pre-existing interventions before NBCCEDP DP17-1701 implementation, regardless of the quality, reach, or current level of functionality.
	Were NBCCEDP resources used toward this <Activity> during this PY? y/n	Identify if NBCCEDP grantee resources (e.g. funds, staff time, materials, contracts, etc.) were used during this year to contribute to planning, developing or implementing this activity
	<Activity> in place and operational at PY end	Implementation stage of this activity at the end of the PY
	<Activity> planning activities conducted this PY	Indicates planning conducted this year for an intervention not in place
	<Activity> sustainability	Indicator of sustained intervention and resources
	If PN in place, # of FTEs delivering patient navigation	
	If PN in place, # of clients navigated	
Section 13: Other Cervical Cancer-related Strategies	Activities to improve HIT use for cervical cancer screening	HIT activities at baseline
	Other cervical cancer-related strategies currently in place	Other activities in place at baseline
	Other <Activity>	<Other cervical cancer activity or strategy>
	Were NBCCEDP resources used toward this <activity> during this PY? (y/n)	



Appendix G: Measuring Breast and Cervical Cancer Screening Rates in Health System Clinics

Breast Cancer Screening Rate Measures

Measure	Reporting Period	Performance Measure	Numerator	Denominator	Appropriate Screening Definition
Government Performance and Reporting Act (GPRA)^a used by Indian Health Service	July 1 – June 30	The proportion of eligible patients who have had mammography screening	Patients who had a mammogram documented in the past two years	American Indian/Alaska Native female patients, ages 52 to 74, with at least two clinic visits in the past 3 years <i>Exclusions: women with a documented bilateral mastectomy or two unilateral mastectomies</i>	Biennial screening mammography for women ages 50 to 74
Health Care Effectiveness Data and Information Set (HEDIS)	Jan 1 – Dec 31; Measures reported to NCQA ¹ annually in June	The percentage of women ages 50-74 who had a mammogram to screen for breast cancer	Patients in the denominator who had at least one mammogram any time on or between October 1 two years prior to the measurement year and December 31 st of the measurement year	Women ages 52 to 74 as of December 31 st for the measurement year <i>Exclusions: women with bilateral mastectomies or two unilateral mastectomies</i>	Mammogram within the measurement year or one year prior
National Quality Forum (NQF) Endorsed Measure	Jan 1 – Dec 31	The percentage of women 50–74 years of age who are up to date with appropriate screening for breast cancer.	Number of patients (aged 52-74) with appropriate screening for breast cancer, who had at least one medical visit during the measurement year.	The number of women 52-74 years of age with a medical visit during the measurement year. <i>Exclusions: Women with a bilateral mastectomy or two unilateral mastectomies</i>	Screening mammography in the measurement year or one year prior to the measurement year.



Cervical Cancer Screening Rate Measures

Measure	Reporting Period	Performance Measure	Numerator	Denominator	Appropriate Screening Definition
Government Performance and Reporting Act (GPRA) used by Indian Health Service	July 1 – June 30	The proportion of eligible patients who have had a Pap test at least once in the past three years	Patients who had one or more screenings for cervical cancer documented	American Indian / Alaska Native female patients, ages 25 to 64, with at least two clinic visits in the past 3 years <i>Exclusions: documented history of hysterectomy; women who refused screening</i>	Pap smear test within the measurement year or three years prior; Pap/HPV co-testing within the measurement year or five years prior if the patient is 30 to 64 years of age
Health Care Effectiveness Data and Information Set (HEDIS)	Jan 1 – Dec 31; Measures reported to NCQA annually in June	Percentage of women 21-64 years of age who were screened for cervical cancer using cervical cytology or cervical cytology / HPV co-testing	Patients in the denominator who received one or more screenings for cervical cancer	Women ages 24 to 64 as of December 31 during the measurement year <i>Exclusions: women who have had a complete hysterectomy with no residual cervix</i>	Pap test within the measurement year or prior two years; PAP/HPV co-testing within the measurement year or prior 4 years
Uniform Data System (UDS)	Jan 1 – December 31; Measures reported annually to HRSA ² in February	Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer	Women with one or more Pap tests during the measurement period or two years prior to the measurement period	Women ages 23 to 64 of age with an office visit during the measurement period <i>Exclusions: Women who had a hysterectomy with no residual cervix</i>	Pap test in the measurement year or previous two years
National Quality Forum (NQF) Endorsed Measure	Jan 1 – Dec 31	Percentage of women 21 - 64 years of age who are up to date with appropriate screening for cervical cancer.	Women (aged 24-64) with appropriate screening for cervical cancer, who had at least one medical visit during the measurement year.	The number of women 24-64 years of age with a medical visit during the measurement year. <i>Exclusions: Women who have had a complete hysterectomy with no residual cervix.</i>	Either: - Pap smear test within the measurement year or previous two years for women 21-64 years of age - Pap / HPV co-testing within the measurement year or previous four years for women 30-64 years of age



Appendix H: How to Write SMART Objectives

For funded partners, program planning includes developing five-year program goals (a broad statement of program purpose that describes the expected long-term effects of a program), strategies (the means or broad approach by which a program will achieve its goals), and annual work plan objectives (statements that describe program results to be achieved and how they will be achieved). Objectives are more immediate than goals; objectives represent annual mileposts that your program needs to achieve to accomplish its goals by the end of the five-year funding period. Each year, your work plan objectives should be based on the strategies you have selected to reach your program goals. Because strategies are implemented through objectives and program activities, multiple objectives are generally needed to address a single strategy. Objectives are the basis for monitoring implementation of your strategies and progress toward achieving your program goals. Objectives also help set targets for accountability and are a source for program evaluation questions.

Writing SMART Objectives

To use an objective to monitor your progress, you need to write it as a SMART objective. A SMART objective is

1. Specific

Objectives should provide the “who” and “what” of program activities.

Use only one action verb, because objectives with more than one verb imply that more than one activity or behavior is being measured.

Avoid verbs that may have vague meanings to describe intended outcomes, like “understand” or “know,” because it may prove difficult to measure them. Instead, use verbs that document action, like “At the end of the session, the participants will list three concerns...”

Remember, the greater the specificity, the greater the measurability.

2. Measurable

Objectives should quantify the amount of change expected. It is impossible to determine whether objectives have been met unless they can be measured.

The objective provides a reference point from which a change in the target population can be measured clearly.



3. Achievable

Objectives should be attainable within a given time frame and with available program resources.

4. Realistic

Objectives are most useful when they accurately address the scope of the problem and programmatic steps that can be implemented within a specific time frame.

Objectives that do not directly relate to the program goal will not help achieve the goal.

5. Time-phased

Objectives should provide a time frame indicating when the objective will be measured, or a time by which the objective will be met.

Including a time frame in the objectives helps in planning and evaluating the program.

Objectives Checklist

1. Is the objective SMART? ☐ **Specific:** Who? (the target population and people doing the activity) and what? (the action or activity).

- **Measurable:** How much change is expected.
- **Achievable:** Can be accomplished given current resources and constraints.
- **Realistic:** Addresses the scope of the health program and proposes reasonable programmatic steps.
- **Time-phased:** Provides a timeline indicating when the objective will be met.

2. Does it relate to a single result?

3. Is it written clearly?

Examples of SMART Objectives

Non-SMART objective 1: Schools will be trained on the selected scientifically based sun safety health education curriculum.

This objective is not SMART because it is not *specific*, *measurable*, or *time-phased*. It can be made SMART by *specifically* indicating who is responsible for training the schools, how many people will be trained, who they are, and by when the training will be conducted.



SMART objective 1: By year two of the project, the Division of Cancer will have trained **75% of elementary schools in districts 1, 3, and 6** on the selected scientifically based sun safety health education curriculum.

Non-SMART objective 2: 90% of cancer survivors will participate in our self-management course.

This objective is not SMART because it is not *specific* or *time-phased*. It can be made SMART by *specifically* indicating who will do the activity, by when, and who will participate in the self-management course.

SMART objective 2: By the end of the calendar year, district health staff will have enrolled 90% of **newly diagnosed** cancer survivors **from the Elms Cancer Community Center in the Chronic Disease Self-Management course**.



Appendix I: NBCCEDP Work Plan Template

Instructions

- Applicants should use the template to document their detailed work plan for Year 1 of the award and provide a general summary of work plan activities for Years 2 through 5 in narrative form.
- The applicant's work plan for Program 1 should include work in all Program 1 strategy areas included in the funding opportunity announcement (FOA). Three strategies (4: Environmental Approaches for Sustainable Cancer Control, 5: Community-Clinical Linkages to Patient Support, and 6: Health Systems Changes*) are the primary strategies to reach the goals of reduced breast and cervical cancer morbidity, mortality, and disparities in incidence and mortality.

*As outlined in the FOA, Strategy 6 includes both activities related to providing screening and patient navigation services (Direct Screening and Patient Navigation) and activities related to implementing evidence-based interventions (Enhancing Service Delivery Using Evidence-Based Interventions). The workplan template includes separate sections for each of these two broad types of activities.
- Applicants are also expected to implement cross-cutting strategies and activities that support primary strategies as outlined in the FOA. Key work proposed in these areas should be included in the Objectives and Activities sections for each primary strategy. Those cross-cutting strategies include 1: Program Collaboration, 2: External Partnerships, 3: Cancer Data and Surveillance, and 7: Program Monitoring and Evaluation Program Management.
- **Annual Objectives:** List SMART **key** objectives you will complete during Year 1. Each objective should include a target date and what is to be accomplished. Completion dates for objectives should vary according to how work should progress. Most objectives will contain a value (number) indicating quantity, percentage, or other progress indicator. See the examples below. Type information describing your monitoring approach in the text boxes provided in the template. You may add boxes, as needed, for additional objectives and activities. Note that the shaded boxes under Status and Challenges and Successes are for completion during CDC's progress review.
- **Annual Activities:** Describe **key** activities you will complete during Year 1. Each activity should designate the person responsible for implementation. Note that the shaded boxes under Status and Challenges and Successes are for completion during CDC's progress review.

Annual Objective Examples

- By December 2017, establish a data system for collecting baseline and periodic screening rates.
- By January 2018, partner with three health systems serving women in a rural part of the state to implement evidence-based interventions aimed at increasing breast and cervical cancer screening.



- By August 2017, establish a protocol for tracking women navigated for screening, diagnostics, genomics, and treatment.
- By June 2018, partner with one employer partner to implement worksite wellness policies aimed at increased breast and cervical screening.
- By August 2017, use state registry cancer data to identify at least two priority populations by key demographic identifiers to inform targeted screening efforts.
- By June 2017, verify that three new non-traditional partners have implemented internal policies promoting screening.
- By August 2017, collaborate with the state cancer coalition to generate an epidemiologic-profile to inform screening targets.
- By September 2017, put a succession plan in place and make sure half of staff can perform a second critical function or support a second critical position.
- By August 2017, put policies and procedures in place to support implementation of a functional area.
- By June 2017, establish a partnership agreement with the local transportation authority to increase rural women's access to low-cost transportation for breast and cervical cancer screening services.



Program Management

Objectives should incorporate the following cross-cutting strategies that support this primary strategy: Program Collaboration, External Partnerships, Cancer Data and Surveillance, and Program Monitoring and Evaluation.

Objectives and Activities	Monitoring Approach					Status	
	Data Source and Collection: How will you monitor?	Frequency: How often will it be measured or assessed?	Baseline: What is the current value?	Target: What is the target value?	Responsible: Who will monitor or implement?	Date Last Assessed: When did you last review data?	Progress
Objectives							
1.							
2.							
3.							
Activities							
1a.							
1b.							
2a.							
2b.							
3a.							
3b.							
Challenges and Successes							



Strategy 4: Environmental Approaches for Sustainable Cancer Control

Objectives should incorporate the following cross-cutting strategies that support this primary strategy: Program Collaboration, External Partnerships, Cancer Data and Surveillance, and Program Monitoring and Evaluation.

Objectives and Activities	Monitoring Approach					Status	
	Data Source and Collection: How will you monitor?	Frequency: How often will it be measured or assessed?	Baseline: What is the current value?	Target: What is the target value?	Responsible: Who will monitor or implement?	Date Last Assessed: When did you last review data?	Progress
Objectives							
1.							
2.							
3.							
Activities							
1a.							
1b.							
2a.							
2b.							
3a.							
3b.							
Challenges and Successes							



Strategy 5: Community-clinical Linkages to Aid Patient Support

Objectives should incorporate the following cross-cutting strategies that support this primary strategy: Program Collaboration, External Partnerships, Cancer Data and Surveillance, and Program Monitoring and Evaluation.

Objectives and Activities	Monitoring Approach					Status	
	Data Source and Collection: How will you monitor?	Frequency: How often will it be measured or assessed?	Baseline: What is the current value?	Target: What is the target value?	Responsible: Who will monitor or implement?	Date Last Assessed: When did you last review data?	Progress
Objectives							
1.							
2.							
3.							
Activities							
1a.							
1b.							
2a.							
2b.							
3a.							
3b.							
Challenges and Successes							



Strategy 6a: Health Systems Changes (Direct Screening and Patient Navigation)

Objectives should incorporate the following cross-cutting strategies that support this primary strategy: Program Collaboration, External Partnerships, Cancer Data and Surveillance, and Program Monitoring and Evaluation.

Objectives and Activities	Monitoring Approach					Status	
	Data Source and Collection: How will you monitor?	Frequency: How often will it be measured or assessed?	Baseline: What is the current value?	Target: What is the target value?	Responsible: Who will monitor or implement?	Date Last Assessed: When did you last review data?	Progress
Objectives							
1.							
2.							
3.							
Activities							
1a.							
1b.							
2a.							
2b.							
3a.							
3b.							
Challenges and Successes							



Strategy 6b: Health Systems Changes (Enhancing Service Delivery Using Evidence-based Interventions)

Objectives should incorporate the following cross-cutting strategies that support this primary strategy: Program Collaboration, External Partnerships, Cancer Data and Surveillance, and Program Monitoring and Evaluation.

Objectives and Activities	Monitoring Approach					Status	
	Data Source and Collection: How will you monitor?	Frequency: How often will it be measured or assessed?	Baseline: What is the current value?	Target: What is the target value?	Responsible: Who will monitor or implement?	Date Last Assessed: When did you last review data?	Progress
Objectives							
1.							
2.							
3.							
Activities							
1a.							
1b.							
2a.							
2b.							
3a.							
3b.							
Challenges and Successes							



Basic Work Plan Narrative: Description of Work in Years 2 through 5



Appendix J: Health System EBI Implementation Template

The Health System EBI Implementation Plan is a management tool for planning the implementation of *Community Guide*-supported evidence-based interventions (EBIs) within partner health systems. A Health System EBI Implementation Plan should be completed in collaboration with each partner health system. The plan is intended to promote program success by ensuring rigorous assessment and planning in the selection of priority EBIs and supporting strategies. A well-constructed Health System EBI Implementation Plan demonstrates your readiness for implementation and likelihood of achieving outcomes. Also, the plan may be useful as a reference to identify what works and what is less productive once implementation begins.

Things to know before you start:

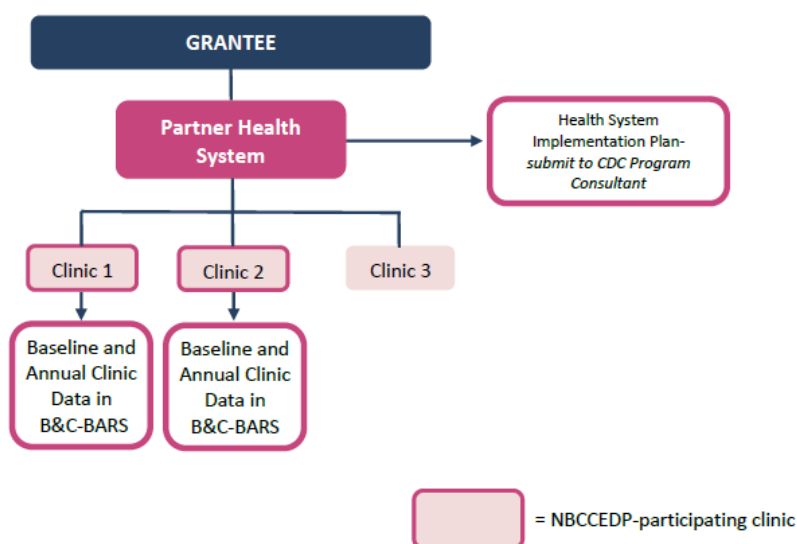
- Develop a separate Health System EBI Implementation Plan for *each* health system in collaboration with the partner.
- **Submit Health System EBI Implementation Plans to your CDC program consultant for review and approval *prior* to implementing NBCCEDP program activities in the respective health system. Your program consultant will review the Health System EBI Implementation Plan and provide approval or feedback within approximately 1 month of receipt.** You may revisit and revise any implementation plan as needed; however, once approved by CDC, you are not required to submit updated versions. You may choose to develop similar plans for each clinic within a health system; however, you are not required to submit these plans for CDC approval. **Note: If you are already working with this partner to implement activities, do not stop. Please submit the implementation plan for existing partners as soon as possible in order to measure improvements over the course of DP17-1701.**
- Complete and submit at least one implementation plan for approval by mid-year of Program YR 1. While at least one plan during YR 1 is required, more may or may not be appropriate for your program. Discuss this with your CDC program consultant. Please focus on the quality of your health systems partnerships and intervention planning rather than trying to expand activities to too many partners too quickly.
- Health systems typically include more than a single clinic site. For instance, a federally qualified health center (FQHC) is often comprised of many clinic sites. You may be planning to implement activities in either all or a subset of clinics (*Figure 1*). As a reminder, within a given health system, clinic baseline data should be collected for *each clinic* where program activities will be implemented. See related CDC evaluation documents on www.nbccedp.org.



- Health systems partners may be existing partners that provide direct service delivery to NBCCEDP-eligible patients, or entirely new partners that serve low income women in a community health center setting. Depth over breadth with your health systems partner is important when developing the implementation plan, supporting evidence-based interventions, and evaluating outcomes. Plan to create an EBI implementation plan for all health systems partners for whom you provide or coordinate regular technical assistance on EBI intervention implementation and collect clinic-level data.

CDC has existing resources and is developing more tools to assist NBCCEDP grantees with health systems partnerships and evidence-based intervention planning. Please discuss your needs for planning tools and resources with your program consultant.

Figure 1. Required reporting for EBI implementation in health systems and clinics



CDC has developed a Health System EBI Implementation Plan template that you may use. If you have your own template, please be sure it contains the information in this template including the following:

- Date of Health System EBI Implementation Plan
- Partner health system name and point of contact
- Implementation time period and number of clinics participating in NBCCEDP implementation
- Description of assessment activities conducted and assessment findings (e.g., health system context; NBCCEDP policies/activities currently in place; health system needs; potential barriers/challenges to implementation; resources available)
- Intervention plan (e.g., objectives; EBIs and supportive activities to be implemented)
- Management plan, including planned program monitoring efforts (e.g., communications plan; implementation support, including persons responsible for this support; process for monitoring implementation of EBIs/supportive activities; sustainability efforts).



[Grantee Name]

NBCCEDP HEALTH SYSTEM EBI IMPLEMENTATION PLAN

Health System Name		Implementation Period	
Health System Point of Contact		# of Clinics Participating in NBCCEDP Implementation	

I. HEALTH SYSTEM ASSESSMENT

Health System Assessment Approach

Briefly describe the assessment approach used to define the current environment within the health system and needed interventions.

Click here to enter text.

(e.g., interviews with key staff, review of clinic and health system data).

Current Health System Environment

Briefly describe the current health system environment: internal/external (e.g., number of primary care clinic sites, existing B&C screening policy and procedures, current screening processes, workflow approach, data documentation, B&C policy mandates from state or federal agencies, political climate, and organizational culture).

Click here to enter text.

Description of Intervention Needs and Interventions Selected

Briefly describe the health system processes and practices that require intervention throughout the health system in order to increase breast and cervical cancer screening. Describe how selected interventions will be implemented in participating clinics. Note if there are differences by clinic.

Click here to enter text.

Potential Barriers and/or Challenges

Briefly describe any anticipated potential barriers or challenges to implementation. Note if there are differences by clinic.

Click here to enter text.



Implementation Resources Available

List or summarize the resources available to facilitate successful implementation (e.g., EHR system, clinic-based patient navigators). Note if there are differences by clinic. Will the program be using Patient Navigators or CHWs to support implementation of evidence-based interventions?

Click here to enter text.

II. NBCCEDP HEALTH SYSTEMS EBI INTERVENTION DESCRIPTION

Objectives

List your program objectives for this health system partnership.

Examples:

1. By December 2017, verify and report baseline breast and cervical cancer screening rates for individuals 50-74 (breast) and 21-65 (cervical) years of age at Health Systems Clinics: Clinic A, Clinic B, and Clinic C.
2. By December 2017, establish system for accurately reporting annual baseline breast and cervical cancer screening rates for individuals 40-75 (breast) and 21-75 (cervical) years of age at health system clinics: Clinic A, Clinic B, and Clinic C.
3. By December 2017, establish new policies at Health Systems Clinics: Clinic A, Clinic B, and Clinic C to support implementation of selected priority evidence-based interventions.
4. From February 2018 to February 2019, implement a provider assessment and feedback system in Clinics A and C, supported by enhanced EHR tickler system and training on quality breast and cervical cancer screening for participating providers in those clinics.
5. From February 2018 to February 2019, implement a client reminder system in Clinics B and C, supported by patient navigation for clients not responding to multiple reminders.
6. Beginning January 2018, annually report screening rates for Health Systems Clinics: Clinic A, Clinic B, and Clinic C.

NBCCEDP Health Systems EBI Intervention Objectives for partnership with:	
1.	
2.	
3.	
4.	
5.	
6.	



III. PLANS FOR PARTNER COMMUNICATIONS, MANAGEMENT, AND MONITORING

Communications with Health System Partner

Briefly describe how you will maintain communications with the health system partner regarding implementation activities, monitoring, and evaluation.

Implementation Support

Briefly describe how you will provide on-going technical support to this health system partner to support implementation success. Include details about who will provide support and frequency of support.

Click here to enter text.

Collection of Clinic Baseline and Annual Data

Briefly describe how you will collaborate with this health system to collect clinic baseline breast and cervical cancer screening rates and annual data to complete CDC-required clinic data forms.

Click here to enter text.

Revising the Health System EBI Implementation Plan

Briefly describe how you will use feedback and monitoring and evaluation data to review and revise this Health System EBI Implementation Plan.

Click here to enter text.

Retention and Sustainability

Briefly describe how you plan to (1) retain partners, (2) continue to collect annual screening and other data throughout the five year grant period, and (3) promote continued implementation, monitoring, and evaluation post-partnership.

Click here to enter text.



Health System EBI Implementation Worksheet

This worksheet assists in identifying, planning, and monitoring major tasks in implementing selected priority EBIs and supportive activities within the partner health system(s) and its clinics. Use this tool for oversight at the health system level. Staff at participating clinics may use this worksheet to guide implementation at their sites as well. Although the boxes in the worksheet will expand, entries should be meaningful and concise. See sample on the following page.

Major Task	Expected Outcome(s) of Task	Challenges and Solutions to Task Completion	Person(s) Responsible for Task	Due Date for Task	Information or Resources Needed



Health System EBI Implementation Worksheet (sample)

Major Task	Expected Outcome(s) of Task	Challenges and Solutions to Task Completion	Person(s) Responsible for Task	Due Date for Task	Information or Resources Needed
Validate the EHR breast and cervical cancer screening rate for each participating clinic using chart review	Accurate baseline clinic screening rate	Challenge: chart audit is costly, time-consuming; no dedicated staff Solution: hire consultant 20%-time to complete	Jackie Brown, Health System Quality Improvement Nurse and Chris Brock, Grantee Partner Data Manager with clinic contact	December 2017	Determine methodology (e.g., proportion of charts to review). Follow CDC guidance In "Guidance for Measuring Breast and Cervical Cancer Screening Rates in Health System Clinics."
For each participating clinic, develop and pilot policy change/protocol in support of selected priority EBI	Policy refined, communicated to staff, and integrated into daily operations and workflows	Challenge: integrating policy such that it is not time-consuming and cumbersome Solution: include staff in planning, vet policy changes, and pilot policy on small scale	Janie Panie, Health System Clinical Officer with clinic contact	February 2018	Policy template
Train clinic staff on selected EBIs	Staff knowledgeable of EBIs and how to implement	Challenge: time to complete training Solution: train during scheduled meeting times	George Lopez, Grantee Partner PD	January 2018	Curriculum
Orient clinic staff to new policy procedures	Staff roles clarified and workflow documented and communicated in staff	Challenge: time to complete training Solution: train during scheduled meeting times	Jackie Brown, Health System Quality Improvement Nurse	January 2018	Final policy
For each participating clinic, develop implementation monitoring process and document outcomes	Implementation monitored regularly, allowing for appropriate adaptations and course corrections	Challenge: staff time, expertise in evaluation limited Solution: recruit evaluator to assist with developing monitoring processes and outcomes	Janie Panie, Health System Clinical Officer Manager with clinic contact	February 2018-February 2019	Clinic-specific workflow outline
Conduct TA with clinics	Implementation according to policy and appropriate adaptations and course corrections	Challenge: Staff time Solution: provide multiple TA options for implementation support- (i.e., one-on-one, teleconference, email, listservs)	George Lopez, Grantee Partner PD	February 2018-February 2019	TA plan